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The Present Status of Tranquilizing Drugs

LEO E. HOLLISTER, *M.D.*, Palo Alto

• **Tranquilizing drugs may be classified into four groups, according to chemical structure: (1) Phenothiazine derivatives, (2) Rauwolfia alkaloids, (3) substituted propanediols or butanediols, and (4) diphenylmethane derivatives.**

The distinguishing features of tranquilizing drugs in contrast to conventional sedatives is that they calm without producing sleep and that their site of action in the central nervous system is predominantly subcortical. The principal sites of action are important regulating centers of the brain: thalamus, hypothalamus, reticular activating system and portions of the limbic system.

Phenothiazine derivatives, besides being the most effective tranquilizers for treating severe emotional disorders, are also clinically useful for potentiating other analgesic or anesthetic drugs and for controlling vomiting. This rapidly growing group of drugs is of major importance in present-day psychopharmacologic therapy. Newer derivatives, especially of the piperazine type, appear to be highly effective as tranquilizers in low doses. They also produce fewer major complications from treatment. Rauwolfia alkaloids have decreased in importance in psychiatric use, but are still the basic drugs for treating hypertension. The substituted propanediols or butanediols are generally used as mild sedatives for less serious emotional disorders. The diphenylmethane derivatives, while chemically related, have a variety of pharmacologic actions which include sedation, stimulation, antihistaminic and anticholinergic effects.

The ultimate role of these agents in the treatment of major emotional disorders, such as schizophrenic reactions, still is uncertain. However, the impetus these drugs have given to improved treatment of psychotic patients in mental hospitals has unquestionably been beneficial. The intensive attempts to determine their modes of action will very likely yield important advances in the understanding of possible neurophysiologic bases for mental illness.

THE TERM "tranquilizers" has been given to a group of drugs with the property of sedating without impairing consciousness. These drugs are now second only to the broad-spectrum antibiotics in dollar sales and number of prescriptions written. They are used in almost every branch of medical practice. Their introduction has been heralded as a milestone in psychiatric medicine and has revolutionized the treatment programs of mental hospitals. The number of these drugs is increasing at a rapid rate. To make matters more confusing, the same compound may appear under a number of different tradenames.*

One can attempt to classify these agents on the basis of clinical indications or the predominant pharmacologic action. However, clinical indications may change with the passage of time and many of these drugs have a variety of pharmacologic actions, the relative importance of which is still not settled. Hence, the best way to classify these drugs seems to be on the basis of chemical structure.

Most tranquilizing drugs fall into one of four general groups, according to chemical structure: (1)

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Submitted April 21, 1958.

*See notes on trade-names at foot of page 2.

Phenothiazine derivatives, (2) Rauwolfia alkaloids, (3) substituted propane- or butanediols, and (4) diphenylmethane derivatives. For the most part, drugs within each group have similar pharmacologic actions, clinical indications and disadvantages.

Phenothiazine Derivatives

Phenothiazine derivatives are currently the most widely used and of greatest research interest. The chemical structures of several tranquilizing phenothiazines currently on the market are shown in Chart 1.

The basis of this group of drugs is the phenothiazine nucleus. This structure may be substituted at two places, the carbon atom at the 2-position or the nitrogen atom at the 10-position. As might be expected, many compounds have been derived from such chemical manipulation. A halogen, either chlorine or a trifluoromethyl group, is frequently substituted at the 2-position. However, methoxy, methylmercapto and acetyl groups, among others, have been placed at the same position or others (the 3-position, for example). The "tail" of the compound, placed at the 10-position, may be either aliphatic (straight-chain) or aromatic (containing a ring structure). Chlorpromazine, promazine, and triflupromazine have aliphatic (dimethylaminopropyl) "tails." Aromatic "tails" include the piperidine ring (connected to the phenothiazine nucleus by a methyl group as in mepazine) or a piperazine ring (connected by a propyl group as in prochlorperazine, perphenazine, and thiopropazote). The addition of aromatic "tails," especially those with the piperazine ring, increases by several-fold the potency of action on the central nervous system. In any case, virtually all phenothiazine derivatives with tranquilizing properties have the nitrogen of the phenothiazine nucleus separated from that of the "tail" by three carbon atoms.

An amazing diversity of pharmacologic actions is exhibited by the phenothiazine derivatives. The sedative effects, so different from those of conventional sedatives as to warrant the use of the epithet "tranquilizing," are well known. Unlike conventional sedatives, chlorpromazine and its congeners calm the excited or anxious patient without impairment of

PHENOTHIAZINE DERIVATIVES

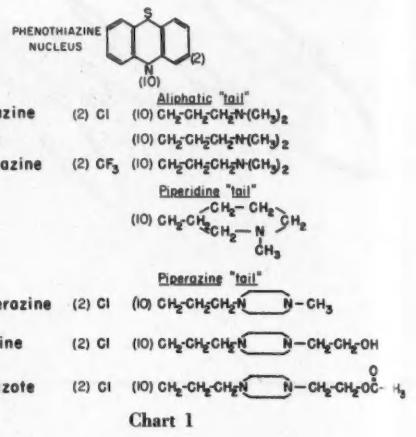

Chart 1

motor function or enforcing sleep. The loci of action in the brain are chiefly subcortical, probably accounting for the different kind of sedation. Chlorpromazine stimulates the amygdaloid complex, a portion of the limbic system. Such stimulation might interfere with the function of this system as well as depress the hypothalamus. The drug also depresses the function of the reticular activating system, a kind of monitor which regulates the intensity with which stimuli are appreciated and the emotional reactions evoked.[13] These effects on these three areas, which are of major importance as neural structures concerned with emotional responses, could account for the tranquilization produced by the drug. Much of the emotional response to external or internal stimuli would be diminished by such actions.

Originally, chlorpromazine was developed to potentiate analgesic and anesthetic agents, an effect which it has shown to a moderate degree. This effect has been used clinically in surgical anesthesia and in treating painful states such as metastatic malignant disease.[25] Antiemetic effects of considerable degree have made some phenothiazine derivatives the drugs of choice in treating nausea.[9,21] The medullary chemoreceptor trigger zone for vomiting is depressed. A similar action may account for the usefulness of this drug in treating hiccough. In addition to the clinically useful effects, phenothiazine derivatives have many which are chiefly of experimental interest, ranging from adrenergic blockade, the production of hypothermia and metabolic effects to the production of an interesting variety of extrapyramidal syndromes.

Chlorpromazine, the first tranquilizing phenothiazine derivative, is one of the most intensively studied of all drugs. Virtually every psychiatric syndrome has been treated, usually with benefit, by this drug.[5,10,16] Particularly important has been the

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Besides the generic names used in this paper, most of these drugs also have trade-names, some having multiple names. The best-known trade-names of each compound are listed below:

Phenothiazine derivatives: Chlorpromazine (Thorazine), promazine (Sparine), triflupromazine (Vesprin), mepazine (Pacatal), prochlorperazine (Compazine), perphenazine (Trilafon), thiopropazote (Dartal).

Rauwolfia alkaloids: Whole root extracts (Raudixin), alseroxylon fraction (Rauwiloid), reserpine (Serpasil, Sandril, Reserpoid, Serpiloid), rescinnamine (Moderil), deserpidine (Harmonyl).

Substituted propane- or butanediols: Meprobamate (Miltown, Equanil), phenaglycodol (Ultran), methocarbamol (Robaxin), 2-ethylcrotonylurea (Nostyn).

Diphenylmethane derivatives: Hydroxyzine (Atarax), benactyzine (Suavatil), azacyclonol (Frenquel), pipradrol (Meratran), isopropamide (Darbid), adiphenine (Trasentine).

ameliorating effect it has on schizophrenic reactions, the most common, most disabling and most baffling of psychiatric disorders. Chlorpromazine is now the standard against which all succeeding psychotherapeutic drugs must be measured. On the basis of studies currently available, it appears that some of the other phenothiazines, especially the piperazine derivatives or the fluorinated compounds, have tranquilizing properties equal to or superior to chlorpromazine.[2,4,11] Some, like prochlorperazine, may be better antiemetic agents. However, the aliphatic compounds (chlorpromazine, promazine, and triflupromazine) still are more useful in potentiating other drugs.

Chlorpromazine may bring about two serious complications, jaundice and agranulocytosis.[15] Neither is frequent, jaundice occurring in fewer than 2 per cent of patients treated for more than a week, and agranulocytosis being a comparative rarity. Although agranulocytosis has occurred with promazine, trifluprazine and mepazine, this complication has not yet been reported from the piperazine derivatives. Jaundice, too, appears to be less likely to occur with the piperazine derivatives. It has been reported in association with mepazine therapy and from promazine in patients previously treated with chlorpromazine. Adrenergic blocking effects, which have led to severe hypotensive crises in some patients treated with chlorpromazine, appear to be less with the newer drugs. On the other hand, the piperazine derivatives produce more severe extrapyramidal signs. In addition to the usual triad of muscle rigidity, resting tremor and loss of associated movements, states of uncontrolled motor activity, oculogyric crises and spasms of the neck, tongue and pharyngeal muscles are frequently encountered. Whether or not the increased frequency of extrapyramidal effects is positively correlated with increased amelioration of schizophrenic symptoms is still a moot point. These manifestations do not usually occur except in association with the high doses used in psychiatric treatment.

Rauwolfia Alkaloids

By a curious coincidence, the ancient plant extracts, the Rauwolfia alkaloids, were introduced to Western medicine almost simultaneously with the increased interest in phenothiazine derivatives. Originally, extracts of Rauwolfia serpentina were studied for their effects on arterial hypertension. Only an incidental observation led to their use as tranquilizing agents.[28]

Among nearly three dozen alkaloids found in the plant, three pure alkaloids are currently in clinical use. The structures of reserpine, rescinnamine and deserpidine are shown in Chart 2. The chemical differences between these alkaloids are slight, as are

RAUWOLFIA ALKALOIDS

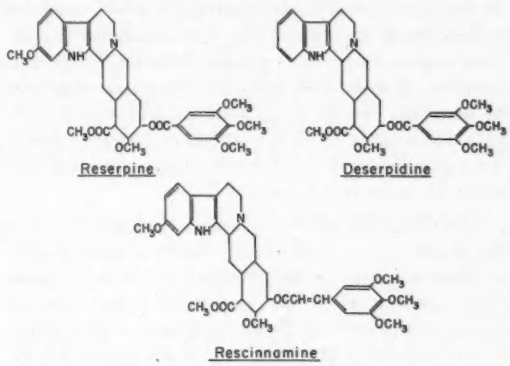

Chart 2

the pharmacologic differences. The pharmacologic actions of whole root extracts or the alseroxylon fraction of Rauwolfia (containing all the alkaloids) are so similar to those of the pure alkaloids as to suggest that these three alkaloids provide the major portion of the activity. Reserpine has been more widely used than any of the individual alkaloids. Although reserpine has been synthesized, attempts to alter its structure and enhance pharmacologic activity have not been very rewarding.

The sites of action of reserpine, like those of chlorpromazine, are chiefly subcortical.[3,19,20] Unlike chlorpromazine, reserpine stimulates the reticular activating system rather than depressing it. For this reason, reserpine is not as powerful a sedative as chlorpromazine. On the other hand, reserpine stimulates the amygdaloid complex much as chlorpromazine does. In monkeys, lesions of the amygdaloid complex produce behavioral effects similar to those of reserpine in normal animals. Alleviation of spontaneously occurring or conditioned anxiety in animals by giving them reserpine has been repeatedly demonstrated. The same is true of chlorpromazine. These actions, on the limbic system, the hypothalamus and the reticular activating system probably account both for the tranquilizing and the antihypertensive effects of the rauwolfia alkaloids. In addition, reserpine facilitates synaptic responses in the spinal cord, which may account for some of the neuromuscular effects of the drug.

These two pharmacologic actions, tranquilization and antihypertensive action, have been the main indications for the clinical use of the alkaloids. As with chlorpromazine, virtually every kind of psychiatric disorder, except mental depression, has been treated successfully with reserpine. For reasons which are still uncertain, Rauwolfia alkaloids aggravate existing cases of depression and may in fact produce it in patients not previously depressed.[7] The

use of reserpine in psychiatry has declined recently. In the more severe psychiatric disorders, such as schizophrenic reactions, the phenothiazine derivatives appear to produce greater benefits, faster and in more patients. The noxious minor side reactions of reserpine (stuffy nose, lethargy and muscle aching) have made other tranquilizers (meprobamate, for example) preferable for treating emotional disorder of the milder types.

The Rauwolfia alkaloids remain the basic drugs in the treatment of hypertension. Early or mild hypertension can usually be managed solely with these drugs. Seldom is it necessary to give more than 2 mg. of reserpine daily, and maintenance doses may be as little as 0.25 mg. a day. Even severe hypertensive states may respond to large doses of reserpine given parenterally. However, practical management of severely hypertensive states over a long term requires combination of reserpine with other agents such as hydralazine, pentolinium or chlorisondamine.

Aside from the bothersome side reactions previously mentioned, the Rauwolfia alkaloids produce few major complications. Mental depression is still potentially the most serious (because of the risk of suicide). Oddly, this symptom seems to occur somewhat oftener in patients treated for hypertension than in psychotic patients. The large doses of reserpine used in psychiatric practice (usually in excess of 2 mg. daily) have been known to activate duodenal ulcers, sometimes with hemorrhage.[14] The danger of this complication is less when hypertension is being treated. Nevertheless, close attention should be paid to ulcer management when such patients receive Rauwolfia alkaloids. Rescinnamine and deserpidine are said to produce less sedation and mental depression than reserpine, alseroxylon fraction or whole root extracts. Thus, these compounds might be preferable for some patients.

Substituted Propanediols or Butanediols

Substituted propanediols or butanediols were developed originally to improve on the skeletal muscle relaxant properties of mephenesin. Meprobamate, the most widely used and studied of this group of compounds, is the dicarbamate form of a di-substituted propanediol. Its structure and the structures of some closely related compounds are shown in Chart 3. The addition of carbamate groups ($CONH_2$) seems to increase the sedative effects of these drugs. Strictly speaking, 2-ethylcrotonylurea is not a member of this group but its structure is shown to demonstrate how the inclusion of carbamate groups relates some of these compounds to the ordinary ureide sedatives, including carbromal and barbituric acid derivatives.

SUBSTITUTED PROPANE- OR BUTANEDIOLS

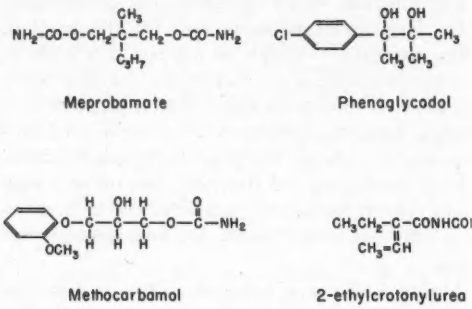

Chart 3

These drugs are mild sedatives and hypnotics. As with the other tranquilizers, the sedative effects seem to outweigh the hynotic. This fact, as well as a subcortical site of action in the thalamus and internuncial neurones of the spinal cord, permits meprobamate and its congeners to be classified as tranquilizing drugs.[12] The muscle relaxant properties of these agents are weak and are only manifest with large doses. Clinical expectations from skeletal muscle relaxants have always exceeded the results obtained. Perhaps it is expecting too much of any generally acting drug to call upon it to alleviate a strongly triggered local muscle spasm. Weak anticonvulsant properties of drugs of this class have also been described.

Meprobamate has been used chiefly for treating temporary anxiety in "normal" persons as well as more severe and chronic anxiety in psychoneurotic individuals. The wide acceptance of this drug, both by patients and physicians, has been astounding. Although few controlled studies of the clinical effects of meprobamate are available, the drug appears to reduce the symptom of anxiety.[26] Whether or not it is superior to barbiturates is a question raised by some observers.[27] A few reports indicate beneficial effects in some schizophrenic patients, although not of the order obtained from the phenothiazine derivatives or Rauwolfia alkaloids. Treatment of depression with meprobamate, either alone or combined with benactyzine, has also been described.[1] The hypnotic properties of meprobamate are probably less than those of the barbiturates.[17] As meprobamate has no appreciable advantage in this regard and is considerably more expensive, barbiturates are to be preferred for treating insomnia.

Allergic reactions, often to the first dose of meprobamate, are the most frequent complication.[5] Withdrawal reactions following abrupt discontinuance of the drug have been described by a number

of observers. Despite the profligate use of meprobamate in emotionally ill patients under poor supervision, only one successful suicide has been reported. As with barbiturates, the use of large quantities of this drug along with alcohol may be expected to produce fatal synergistic effects.

Diphenylmethane Derivatives

The chemical structure of the diphenylmethane derivatives, which permits considerable substitution, has allowed the creation of many derivatives with a sometimes confusing array of pharmacologic actions. Some of the more interesting derivatives are shown in Chart 4.

Hydroxyzine is both a sedative and potent antihistaminic. It has been used much as meprobamate is used in treating milder emotional disorders, as well as for treatment of skin disorders.[20] Benactyzine is also an anticholinergic, which is understandable, for it differs from adiphenine, one of the earliest synthetic anticholinergics, only in that it lacks an oxygen atom. Benactyzine is said to be useful in treating psychoneuroses, especially the specific symptoms of phobia and compulsion.[6] Azacyclonol has puzzled many investigators. The drug is said to block in man the model psychoses produced by lysergic acid diethylamide (LSD) and mescaline, and the electrographic changes produced by LSD in the reticular formation of rabbits.[8,23] It is said to be useful clinically in treating confusional states and the specific symptom of hallucinations. However, many investigators have been hard put to find any demonstrable clinical pharmacologic effects from the drug, even in large doses. The relative lack of therapeutic effects has practically eliminated the drug from current use in psychiatry. On the other hand, its isomer, pipradrol, is definitely a mild stimulant. Another drug of this series, isopropamide, is a rather long-acting and potent anticholinergic. Methylphenidate, a mild stimulant, is fairly closely related to this group.

Some of these diphenylmethane derivatives have a future in clinical use. Hydroxyzine, which has little or no toxicity, is being increasingly used as a sedative. Pipradrol and methylphenidate have found a place as mild stimulants that have somewhat less sympathomimetic effects than the amphetamines. However, drugs such as benactyzine and azacyclonol, despite an apparent lack of serious toxic effects, have not yet found a place in clinical medicine.

DISCUSSION

Few previous situations in medicine compare with the rapid development of tranquilizing drugs in the short span (less than five years) of their use. The

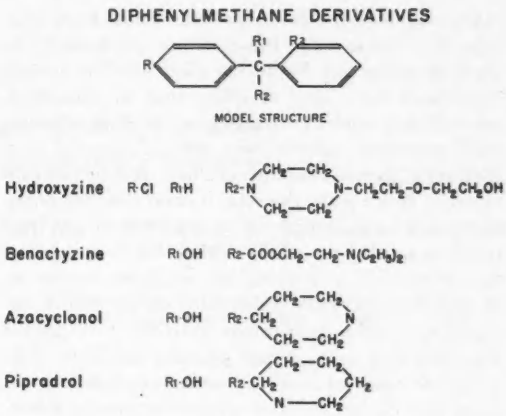

Chart 4

sulfonamides and antibiotics come immediately to mind, but compared with the tranquilizers these agents progressed at a leisurely pace. The rapid evolution of tranquilizers is in part a reflection of a widespread public need for comfort in what has been dubbed an "age of anxiety." Then, too, the recent appreciation of mental illness as one of the costliest of human afflictions, both in terms of personal tragedy and public expense, has had its influence. The fact that chemical agents may ameliorate schizophrenic reactions has engendered some hope for the solution of this monumental problem. Finally, the development of a successful tranquilizing drug is a highly profitable venture for even the most altruistic pharmaceutical house. The intense competition for markets and prestige has contributed much to the speedy exploitation of these agents.

A great many social commentators, not all professional viewers-with-alarm, have decried the excessive use of these agents by "normal" persons. Even the most complacent observer must admit that these drugs have been abused. A conscientious physician must always do what is good for the patient, not what is most expedient. For some patients, a tolerable amount of anxiety which leads to problem-solving is far better than a temporary though pleasant relief. The tranquilizing drugs should be used when anxiety becomes disabling, and then only when coupled with efforts to find and remove the source of anxiety. While the taking of tranquilizers might be preferable to a rising tide of alcoholism (or, in other cultures, smoking the dried juice of poppy buds or chewing coca leaves), it should not be encouraged as a national practice.

Tranquilizing drugs have been heralded as a major breakthrough in the problem of schizophrenia. Scarcely anyone free of prejudice can deny that

many severely psychotic patients have been considerably helped by these drugs, especially the phenothiazines and Rauwolfia alkaloids. For acutely ill patients the course of illness may be shortened, permitting a briefer period in hospital. Many chronically psychotic patients who seemed doomed to a lifetime in mental hospitals are now able to function outside. As a result, the total mental hospital population is now beginning to decline, reversing a long trend upward. The effects within the hospital and on patients still in hospital has also been beneficial. Mental hospitals have accelerated efforts to become treatment centers rather than custodial institutions. The fact that many more patients are now able, owing to tranquilizers, to participate fruitfully in psychiatric rehabilitation programs has provided much of the impetus. While the total effect is still pitifully small, tranquilizing drugs have provided some measure of hope for these patients.

Perhaps more important than the benefits of these drugs for individual patients may be the renewed interest they have aroused in the neurophysiologic bases of mental disorders. These drugs act in areas of the brain which have been found to be important in emotional reactions and the expression of those reactions: The thalamus, hypothalamus, reticular activating system and the limbic system. Indeed, the subcortical action of these drugs is the major distinction between them and conventional sedatives. The fact that reserpine releases serotonin, a neurohumoral agent, from the brain and that chlorpromazine has a potent anticholinesterase activity suggests that these drugs might act by neurohumoral mechanisms.[22] They also affect synaptic transmission in the brain, which it has been postulated may be disturbed in cases of mental disorders.[18] Finally, the relationship of these agents to hallucinogenic substances, especially their ability to block the psychotomimetic actions, may be relevant to the problem of psychosis. However, despite an increasingly intensive investigation of these phenomena, the relative importance of any of them to the cause and treatment of schizophrenic reactions remains conjectural. Fortunately, in medicine we have neither to know the cause of the disease nor the way a treatment works in order to practice therapeutics successfully.

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Hirschsprung's Disease

The Clinical Differentiation and Treatment of Children with Hirschsprung's Disease and Pseudo-Hirschsprung's Disease

MARK M. RAVITCH, M.D., Baltimore, Maryland

• **Hirschsprung's disease is marked by constipation from the time of birth, with the development, if uncorrected, of a protuberant abdomen and flared costal margins. The rectal ampulla is empty and the abdomen is filled with fecal masses. Pain is not prominent. Flatus is passed in large amounts. Encopresis does not occur. Barium enema shows the characteristic narrowed distal rectal segment and biopsy of the rectum shows absence of the ganglion cells of the myenteric plexus.**

Treatment is operative resection of the distal narrow segment and a primary anastomosis.

Hirschsprung's disease may be mimicked in children with:

1. Psychogenic constipation—pseudo-Hirschsprung's disease. Unlike Hirschsprung's disease, symptoms do not appear at birth, encopresis is common, and the barium enema shows no narrow distal segment.

2. Mental retardation and cerebral defect.

3. Corrected imperforate anus—on the basis of stenosis, imperfect innervation or poor habit training.

4. Cretinism—with severe constipation and intestinal dilatation perhaps the presenting symptoms.

Treatment of these four groups of children with severe constipation not due to Hirschsprung's disease is:

For Group 1, open discussion with parent and child. Assumption by the physician of full control of the details of treatment, and relegation of parent to the role of the physician's agent in following the prescribed regimen.

For Group 2, an enema regimen. Whereas fairly rapid restoration (and then persistence) of normal bowel habit can be expected in Group 1, the basic defects in Group 2 may require indefinite continuation of treatment.

For Group 3, regular enema regimen, in the less severe cases—one identical with that used in Group 1, and dilatation of strictures or anoplasty.

In Group 4, thyroid hormone therapy relieves the constipation of hypothyroidism and causes reversion of radiographic changes in the colon and rectum.

WHEN HIRSCHSPRUNG in 1888[5] made his initial report on the disease which today goes by his name, he made a number of observations which remain valid today. He pointed out that in both of his patients difficulty with evacuation had begun at birth, that in both of them the colon was enormously dilated and hypertrophied, but that, despite this, in both of them the rectum was of normal diameter, or actually decreased in caliber. He also made the observation that the mucosa of the dilated segment was ulcerated and inflamed and he postulated that this was the result of obstruction and the retention of fecal masses.

In true Hirschsprung's disease, if a reliable history in the obstetric nursery is available, distention, constipation and the necessity for enemas almost from the time of birth will regularly be noted. The condition persists or progresses. The abdomen becomes enlarged and protuberant. The costal margins flare. Fecal masses are repeatedly palpable in the abdomen. The children rarely pass stools spontaneously and then only scybala. Flatus, on the other hand, is passed with annoying frequency and in large amounts. A successful enema brings about evacuation of huge quantities of stool. Then for perhaps a day or two there are inadequate evacuations, and then obdurate constipation. Pain sometimes occurs, but is not common. Distention may be so extreme as (in infants) to cause death from respiratory embarrassment, with the diaphragm so high that the diagnosis of eventration has been made at times. Repeated hospital admissions are required for crises of constipation. With assiduous home care and regular enemas such crises may be made infrequent but are rarely altogether eliminated. Incontinence does not occur. At times ulceration of the distended bowel, described and correctly interpreted by Hirschsprung as secondary to stasis and erosion by fecal masses, results in bloody diarrhea concomitant with continued distention and palpable abdominal fecal masses. Ordinarily, sphincter tone is normal and the rectal ampulla is empty.

Despite the fact that many observers suggested that the disease was neurogenic in origin and despite the fact that a number of papers described the absence of the ganglion cells of the myenteric plex-

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uses in groups of children with congenital constipation, the true nature of the disease remained unclear until about ten years ago. At that time Neuhauser and Swenson[10] demonstrated the characteristic radiologic appearance of the barium enema in Hirschsprung's disease. They showed that there was invariably a normal sized or narrow rectal segment and a dilated proximal sigmoid or descending colon. Reasoning that this narrowed segment was at fault, Swenson devised a method for performing an external anastomosis, quite close to the anus, in order to obviate the difficulties of a low intrapelvic anastomosis after resection of the rectum and distal sigmoid. The results were immediately striking and the operation has been widely accepted. When the operation, with minor modifications, was undertaken by Stephens and Browne at the Hospital for Sick Children at Great Ormond Street, their pathologist, Bodian,[3] reported that, in the distal narrow segments which were resected, the ganglion cells of the myenteric plexus were systematically missing.

The treatment of Hirschsprung's disease is therefore now on a sound basis. We have a sharply drawn clinical picture, a pathognomonic radiologic finding, an invariable histologic finding, and a well conceived and effective operative procedure. It is, of course, possible to manage many of these children by a careful regimen of cathartics and enemas, but this seems hardly wise. At times, even with the most conscientious management, almost complete intestinal obstruction results, and in infants this may frequently require colostomy.

My preference is for the Swenson type operation, but with this modification. Instead of resecting the bowel and then pulling down the divided proximal end, I prefer to divide the mesentery of the bowel which is to be resected and then to intussuscept this bowel through the distal bowel, pulling the entire intact specimen out through the anus. The bowel is transected close to the anal crypts and a two layer anastomosis performed upon the extruded cut ends. This is done when the abdomen is still open, so that, if necessary, more bowel may be freed. Incontinence does not seem to occur, and since the dissection is carried close to the bowel, there is no need to anticipate the occurrence of sexual impotence in males.

The knowledge that an effective surgical treatment is available has perhaps led to more frequent early surgical consultation in children with obstinate constipation. I am more frequently asked for a surgical opinion relative to operation for Hirschsprung's disease in children with some other kind of condition, than relative to children with true organic Hirschsprung's disease.

Patients referred for treatment of megacolon in whom the difficulty lies elsewhere than in the congenital absence of ganglion cells of the myenteric plexuses of a segment of the rectum, or of the colon and rectum, may be divided into four categories—those with:

1. Pseudo-Hirschsprung's disease on a psychogenic basis in otherwise normal children.

2. Megacolon and obstinate constipation in mentally defective children.

3. Megacolon and obstinate constipation associated with organic anal obstruction.

4. Megacolon and obstinate constipation in congenital cretins.

With the clinical characteristics of these conditions kept in mind, there should be little or no difficulty in diagnosis.

1. Pseudo-Hirschsprung's Disease on a Psychogenic Basis in Otherwise Normal Children.

This is far commoner than the organic disease that is due to absence of the ganglion cells of the myenteric plexus. The patients still often are classified as having "idiopathic megacolon." Discussions of the therapy of this condition are rare, and frequently it is either described as "extremely difficult to cure" or is totally neglected.

Characteristically, medical advice as to the children is sought when they are at the age of three to four years or thereafter. A history of constipation beginning in the third or fourth year or later is usually clearly obtainable. The pathognomonic give-away—almost regularly occurring and frequently forming the presenting complaint jointly with constipation—is fecal incontinence. Fecal incontinence never occurs in Hirschsprung's disease, and if it occurs at all the possibility of that diagnosis is foreclosed. In the group of children under discussion, distension is moderate, unlike the situation in Hirschsprung's disease, or is entirely absent. Flatus is not conspicuous. Fecal masses may be quite as large and hard as may be found in Hirschsprung's disease. Abdominal pain is a common event. The perianal region is often smeared with feces. The anus and sphincter are normal, and the rectal ampulla is filled with a mass of feces, often filling the pelvis. The most superficial questioning readily elicits rich evidence of tension, hostility and neurotic difficulties in parents and child. Oddly, while the mother is usually mortified by the encopresis, the child often appears to accept it calmly, matter-of-factly, without evidence of shame or agitation. This will obviously depend, to some extent, upon the degree to which the mother impresses her reaction upon the child and the degree to which the child has withdrawn into its shell. Quite often there is a sharp history of extremely early habit training.

Some of these children "fought the pot" and successfully resisted such premature attempts. Others appeared to surrender gracefully and tractably, and their subsequent relapse into repulsive delinquency is all the more harrowing and perplexing to the obsessive mothers who took such pride in their earlier triumphs.

Huschka,[6] who has been interested in the psychiatric aspects of the problem, said that the infant shows its awareness of the need to defecate by physical signs such as grunting and wriggling, usually between the ages of eight months and fifteen months. She estimated that "training" can usually be completed by the ages of 18 months to two years. In a discussion of coercive training methods, she mentioned the premature institution of training (infants can actually be taught a sort of reflex continence at two to three months), rigidity of schedule, unduly frequent placement on the toilet, employment of shame as punishment for failure, psychological pressure by placing a "high love premium" on success, strapping the child to the seat until success is achieved, use of suppositories for stimulation or forcing a child to "speak up" and announce his wants when he is just learning to talk. Threats, bribes and punishment are obvious coercive methods.

Huschka found that in a group of disturbed children whose primary problem was not constipation or encopresis, there were 30 in whom there was an adequate history of the use of coercive methods and in whom the child's reaction could be reliably elicited. Twenty-one of the 30 had responded by constipation or loose stools, rage, incontinence or obsession with excessive cleanliness. Response of this type is natural and understandable. The encopresis in pseudo-Hirschsprung's disease may vary from regular overflow soiling of the clothes when the child is finally unable to restrain defecation, through regular and complete evacuation into the clothes at long intervals, to bizarre habits of defecation about the house. It has been noted that many of these children defecate when standing—evidence perhaps of an unyielding wish to avoid defecation. While it is often said that the encopresis represents failure of inhibition of defecation, it has at times seemed apparent to me, and presumably to the children at some level of consciousness, that encopresis represents as effective a weapon against authority as does constipation.

Roentgenograms in pseudo-Hirschsprung's disease of this kind show a large, redundant, atonic colon which may well mimic the colon in Hirschsprung's disease with regard to size, and to quantity of retained stool. Proper studies will show the dilatation to involve the rectum and reach the anal canal. The narrowed segment that is characteristic of Hirschsprung's disease is never seen. The diagnosis can usually be made on history alone. In some cases the reasons for fixing attention on the bowel are obvious and in others less so. In rare instances, biopsy of the rectal wall may be required to determine the presence or absence of ganglion cells. The following cases are illustrative.

CASE 1. A five and a half year old white boy had progressive constipation from the seventh month. He had had no difficulty until that time, had sat up at five and a half months, walked at 12 months. Habit training was begun at five and a half months and was said to be difficult because the child would sit indefinitely. He began to rebel against sitting on the toilet; he cried and struggled. The constipation was progressive until he would go five to seven days without a stool. On the fifth and sixth such day he might vomit. Rarely, he complained of pain. Abdominal distention was never pronounced. Fecal impaction required manual extraction about once in six months. No treatment had been given, the mother waiting until he had a stool—and "he usually does"—with manual assistance from her if necessary. The child had always been hard to feed.

A cardiac murmur, noted at the age of four weeks, led to proscription of much normal physical activity. At the time of examination the child was deliberately and repeatedly hysterical, screaming or complaining in rapid succession of hunger, abdominal pain, and the like. He cried, jumped about, beat his face with his hands, pulled at his mother. He could be made to calm down by a show of quiet firmness and, with his mother out of the room, was completely tractable. The abdomen was not protuberant, there was a fist-sized, freely movable fecal mass in the right upper quadrant and several smaller very hard masses throughout the abdomen. Rectal examination showed good sphincter tone and a capacious ampulla filled with feces. Barium enema showed a voluminous redundant colon which evacuated poorly.

The mother was extremely obsessive. It was obvious from her account that every minute of the child's life had been planned and sharply observed, that perfection had been expected of him and absolute regularity of performance in all respects demanded of him.

The home situation seemed so difficult that the child was admitted to the hospital. Enemas, given twice daily for one week, were productive each time of large amounts of soft stool. At the end of a week the enemas were stopped and the child continued to have one or two large movements per day without any difficulty at all. He stayed in the hospital for two more weeks, having normal and regular bowel movements.

In this instance an obsessive mother smothered her child with care, perhaps because of the cardiac murmur, and premature attempts at bowel habit

training focussed the child's rebellion in that direction.

Obviously the relief obtained by such therapy is no more than symptomatic. The fundamental problem would require prolonged psychotherapy of the mother. However, both the mother and child were convinced that the child could have daily bowel movements without any continued treatment, and a very troublesome symptom was relieved.

CASE 2. The patient was a six and a half year old boy who had been born one of two premature fraternal twins. His twin was larger, more athletic, more aggressive. The patient was less well coordinated, had a decided squint and required glasses. The patient had been born with a thin membrane over his anus, which was opened by a surgeon. From early childhood the patient had had trouble with defecation and numerous remedies had been tried. Repeated x-ray studies had showed the colon to be enormous. The boy was able to go a week or more without a stool. At times he had abdominal pain, and rarely he vomited. On the other hand he would at times go as long as two or three months without missing a day's defecation. His underclothing was frequently heavily soiled. The mother said that on repeated occasions when she and the father were away travelling, the child evacuated daily. On the other hand the difficulty with constipation was likely to be aggravated at any time his twin brother achieved some new talent, like swimming or riding a bicycle, before the patient did.

Upon examination the patient was observed to be an obviously bright little fellow with thick-lensed glasses. The abdomen was full and there were numerous loops of feces-packed bowel and several large, hard fecal masses. The anus admitted the examiner's finger easily. The sphincter tone was good. Immediately within the sphincter was a great mass of moderately firm feces. When the numerous barium enema examinations which had been performed over the preceding several years in an attempt to diagnose or exclude Hirschsprung's disease were reviewed, the colon was seen to be greatly dilated, particularly the sigmoid, which was very large and never seen empty. There was no narrow segment.

The family and the boy were told together that with the proper management this condition could be entirely corrected. On the prescribed regimen he began having spontaneous stools almost at once, with occasional brief periods of constipation, usually coinciding with deviations from the planned program. By the end of the month he was having very little difficulty. He had never soiled since his first visit. It was actually ten months before perfectly normal bowel habit was firmly established. At the end of 14 months the family and the boy were told he was perfectly well, that his bowel could be totally ignored, just as would be a fractured leg which had healed. He had no abnormality of bowel habit afterward.

In this instance the physically less fortunate member of fraternal twins reacted to difficulties by constipation and incontinence. The presence at birth of an anal membrane and the family's subsequent preoccupation with the possible significance of this anomaly amply explains the form in which the patient expressed his reactions.

Instances could be multiplied, but in every case there is good evidence of some emotional disturbance in the family situation and in every case the constipation did not begin at birth, and in almost every case incontinence is a conspicuous feature. It takes more than poor training methods to produce a reaction of this type in a child. A number of the children with this condition come from broken homes, and others come from homes in which there is severe tension. The poor training methods appear, if anything, to be no more than symptomatic of the maladjusted parental personality, and it is therefore not surprising that a number of these children showed substantial deviations from standard behavior in other respects than bowel habit. It can hardly be disputed, therefore, that proper treatment of these children would require extensive psychiatric work with both parents and children. Of first importance, however, is the necessity for immediate recognition of the diagnosis, and the separation of this condition from true Hirschsprung's disease. The sooner and the more firmly such a distinction is made, and the fact impressed upon parents and patients that operation is out of consideration, the sooner can rehabilitation be begun.

Psychiatrists generally take the attitude that constipation and incontinence are merely symptoms which not only can be ignored but should be ignored, in order not to focus further attention on the anus and on the act of defecation.

Undoubtedly excellent results can ultimately be obtained purely by psychiatric treatment of the patient and family. This is laborious, expensive and may require many months or years of repeated visits by patients and parents. On the other hand, where several years of intensive family concern have been concentrated on the act of defecation, it is unlikely that a few weeks or months of further attention in the form of treatment such as has been indicated in this discussion, will alter the picture in any harmful way. Furthermore, the symptom itself is an extremely annoying and disturbing one—always to the parents, and frequently to the patients. Direct relief of the symptoms may very well facilitate the problem of psychiatric handling of the patient and family.

Most of the children referred for examination because of symptoms referable to this condition are five or six years old or older, although symptoms had usually been recognized from the age of three or four, or occasionally a little earlier. Hence it is possible to talk with the children as well as with the parents. I make a point of speaking to the patient and parents jointly and explicitly, and religiously avoid additional side conversations with either. They are told that this is a matter of habit training, that it can be corrected by proper training, that there is no organic abnormality of the bowel, and that operation will not be considered at all. They are told that a precise regimen will be prescribed, that deviation from it will not be tolerated, and that responsibility for the regimen is taken entirely out of the hands of the parent, who has no discretion in following the orders of the physician or in deviating from them. This comment, itself, is extremely important, for once the child understands that the parent is merely a passive agent of the physician, he finds less profit in thwarting the parent. At the same time, once the parent knows, and is aware that the child knows, that primary responsibility has been shifted from the parent to the physician, the parent is in a position to follow instructions without responding to pressure from the patient, and without feeling that there has been any surrender to the patient.

In a few instances—those in which the home situation is extremely disturbed or the patients come from a distance and cannot be continuously observed, or the parents are so loath to believe that the condition is not organic and does not require an operation that it is feared they will not be capable of cooperating with the prescribed regimen—in such cases it is necessary to admit the children to the hospital. Hospitalization alone is frequently all that is required to straighten out the bowel habit in such children, at least for the period of hospitalization, and one frequently obtains from the history accounts of symptom-free periods when the parents are away from home, or when the children are visiting relatives. The principal virtue of putting the patient in hospital lies solely in the fact that the mother can be convinced that the child can achieve a normal bowel habit and that the child can be convinced that the physician knows this. In most cases successful treatment can be carried out on an out-patient basis, substantial success being achieved within a period varying from two or three weeks to two or three months.

To begin with, the patient is given as many large tap-water enemas as are required to empty the colon completely of the inspissated fecal masses. After consultation with the parent and discussion of the whole situation, a decision is made as to the most convenient time in the family schedule for the child's daily bowel movement. Usually this will be immediately after breakfast. Occasionally circumstances will suggest that it would be more convenient immediately after the evening meal. Parent and child are instructed that for the first two weeks daily at the appointed time, and without any preliminary discussion and without threats, bribes, rewards or postponement, a one-quart enema of warm tap-water is to be given. This is to be given whether the child has spontaneous stools in the interim or not.

At the end of two weeks the child and mother are seen again. If the regimen has not been strictly adhered to they are instructed to adhere to it strictly and to return in a week. Once the parent and child are convinced that there is no recourse but to follow instructions precisely, improvement will follow readily.

For the next two weeks the child goes to the toilet seat at precisely the same time that the enemas were given. He and his mother are instructed that at the end of ten minutes the mother will inspect the toilet bowl. If there is a large and copious stool, no more need be done. If there is no stool, or only a small one, a one quart, warm tap-water enema is given at once. Again this is without discussion of any sort, but entirely automatically; and it is made plain that no delays for further efforts are to be considered. Usually within two to four weeks the child will be found to be evacuating daily without an enema. Once this pattern is established, both parent and child are strongly encouraged, and the occasional lapses are found to be farther and farther apart. Once regularity is apparently firmly achieved, mother and child are instructed to forget all about the problem of defecation on the basis that the child has a normal bowel, now has a normal bowel habit and needs no more attention to defecation than does anyone else.

It is perfectly true that there is no valid reason for requiring everyone to have a bowel movement every day. On the other hand, the foregoing method has proved to be simple and effective. No drugs of any kind are employed. If habitual constipation is too long neglected, there may finally emerge a habit of chronic constipation which is not correctable and requires a lifetime of enemas and cathartics.

2. Megacolon and Obstinate Constipation in Mentally Defective Children

There is certainly no reason to suppose that there will not be an occasional child with true Hirschsprung's disease who also has an organic cerebral defect. On the other hand this will manifestly be a great rarity, while more commonly chronic constipation, perhaps with encopresis, will be prominent in a mentally defective patient. Among such cases

in my records are that of a child four and a half years of age with agenesis of the right cerebral hemisphere, and another in which the patient was microcephalic. Both were referred for consideration of surgical relief of chronic constipation.

The therapy in mentally defective children with obstinate constipation depends upon administration of enemas daily with absolute regularity. These serve the purposes of emptying the colon, avoiding retention of feces and avoiding the nuisance of encopresis on the one hand and in addition holding the promise of ultimately establishing the kind of automatic bowel habit that can be obtained even in patients with abdominal colostomy.

3. Megacolon and Obstinate Constipation Associated with Organic Anal Obstruction

One would suppose that if there is a straightforward history of an imperforate anus with surgical repair at birth, later constipation and incontinence would be attributed to this condition and to the operation and not to Hirschsprung's disease. The fact is that even though very good continence is achieved with successful repair of an imperforate anus, it is not always easy to establish good bowel habit. Whether this is due to psychologic reasons, with heavy concentration on the abnormal area by the anxious family, whether it is due to organic stricture (as it surely is in some cases), or whether it is due, as Swenson postulates, to the fact that the bowel which is brought down to the anus is not normally innervated, the fact remains that regular bowel habit is frequently difficult to establish. I was astonished to find, in not extremely old records, five cases in which the patients had had imperforate anus, with surgical correction, and subsequently were observed at the hospital for "megacolon." These patients came to the hospital with complaints of constipation, distention, encopresis and fecal impactions due to failure to prevent stricture formation in the operative area. It is embarrassing to report that one of these patients had actually had sympathectomy for putative Hirschsprung's disease (this was before 1949) and that another was advised to have sympathectomy but the operation was refused and a plastic operation on the anus, done later at another hospital was entirely successful. A letter from the patient years later reported that he was normal and had a perfectly normal bowel habit despite the fact that the colon had once been enormous.

Conceivably an imperforate anus may occur in a child with absence of ganglia in the myenteric plexus. This will be so rare as scarcely to be worth considering. In the children under discussion, dilation of the stricture and proper habit training will achieve relief. Anal plastic procedures are most infrequently required.

4. Megacolon and Pseudo-Hirschsprung's Disease in Congenital Cretins

Intestinal disturbances in association with myxedema are well known and constipation is the commonest. Abdominal distention and functional megacolon or dolichocolon have been described, with great dilatation of the entire intestine and even of the stomach. These changes respond to treatment with thyroid extract and are reversible if treatment is not too long delayed. In newborns and infants in whom the diagnosis of cretinism may not be readily apparent, abdominal distention and obstipation may be the presenting symptoms. The clinical features may strongly resemble those of Hirschsprung's disease; indeed in a case reported by Salmi and Lakesmaa[8] they were indistinguishable from those of Hirschsprung's disease. The patient in the latter case was a girl baby who became constipated at the age of three weeks and was first examined therefor at the age of four weeks. A plain x-ray film of the abdomen showed distention of intestines, and at six weeks there was great distention of the colon and a roentgenographic study with barium enema was absolutely typical of Hirschsprung's disease. At this time there was a suggestive appearance of myxedema, but a diagnosis of Hirschsprung's disease was made and non-operative therapy was prescribed. When the patient was three months old she was passing stools at intervals of three to four days but by then appeared typically myxedematous. Therapy with thyroid extract was begun, and immediately the myxedematous appearance abated. After three weeks a barium enema study was essentially normal and the bowel functioned regularly. I have seen two children with cretinism in whom a large abdomen and severe and stubborn constipation were the most prominent symptoms, and in whom, for a time, the diagnosis of Hirschsprung's disease was maintained.

Obstinate constipation, of course, may also be a symptom secondary to acquired hypothyroidism.

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• **A heart-lung machine capable of oxygenating the blood and maintaining normal pressures during cardiopulmonary by-pass was used in 11 cases in which cardiac operations with the heart under direct vision were carried out. The first patient died. Improvements then were made in the machine and it was used in ten additional operations. One of the ten patients died, 18 hours postoperatively, of cardiac tamponade. Since then six more patients have been operated upon with no complications.**

IN THE MIDDLE 1930's Gibbon of Philadelphia began work on an apparatus which would be capable of performing the functions of the heart and lungs. He felt that this would enable surgeons to operate upon intracardiac anomalies under direct vision—open heart operation—in a relatively dry, bloodless field while the brain, myocardium, liver, kidneys and other tissues received adequate flows of oxygenated blood. In 1953, after many years of research, Gibbon reported the first successful operation on the heart of a human subject with the operative field visible and a heart-lung machine oxygenating the blood. The operation consisted of closing an atrial septal defect. In 1954, Senning and Crafoord in Sweden successfully removed a pseudomyxoma of the left atrium. In March, 1955, Kirklin of the Mayo Clinic began to perform operations in which a heart-lung machine of the Gibbon type was used for extracorporeal circulation.

At about the same time Lillehei of Minneapolis started a series of direct-vision intracardiac operations in which controlled cross circulation was used. He soon abandoned cross circulation for the DeWall bubble oxygenator.

At present, there are only two practical methods of oxygenating the blood; one is spreading the blood in a thin film in an atmosphere of oxygen, and the other is mixing bubbles of oxygen in the blood. Disadvantages of the bubble oxygenators are that they cannot maintain sufficient oxygenation for adequate flow, the complete removal of bubbles is difficult and the method destroys many of the constituents necessary for clotting of the blood.

The authors of this communication have used bubble oxygenators, hypothermia, reservoir perfusion and homologous lung oxygenators and have turned away from them as it seemed that the most promising approach to open heart operations was offered by extracorporeal apparatus using the filming technique. Two of us (Kay and Anderson) developed a pump oxygenator apparatus (Figure 1) from three years of research work in which more than 300 experimental operations employing total cardiac by-pass were carried out.

The pump oxygenator is run in the following manner: Blood is returned by gravity drainage from the superior and inferior venae cavae to the venous reservoir. It is then pumped by way of a roller pump to the distribution chamber at the top of the oxygenator. From there it flows onto a series of 12 screens which are suspended from the distribution chamber. Ten liters per minute of a mixture made up of 97.5 per cent oxygen and 2.5 per cent carbon dioxide flow into this chamber and oxygenate the blood. The blood passes through a filter and is pumped into the aorta by way of the femoral artery or subclavian artery. The apparatus is capable of oxygenating and delivering an amount of blood equal to normal cardiac output.

Three milligrams of heparin per kilogram of body weight are used to prevent clotting of blood in the apparatus during perfusion. After by-pass is effected, an equal amount of protamine is used for neutralization of the heparin. In experiments on animals undergoing total cardiac by-pass for a half hour to an hour, it was noted that there was 10 to 20 per cent decrease in the platelets and fibrinogen. There was no postoperative clotting difficulty and the animals received the same amount of blood as they would for routine thoracotomy. There was very little destruction of red blood cells during the period of perfusion and the amount of hemolysis in a half hour to an hour of cardiopulmonary by-pass was less than 50 mg. per 100 cc. of blood. Metabolic acidosis did not occur during or after the period of by-pass. The amounts of pyruvic and lactic acids were within normal limits. In the last 12 consecutive

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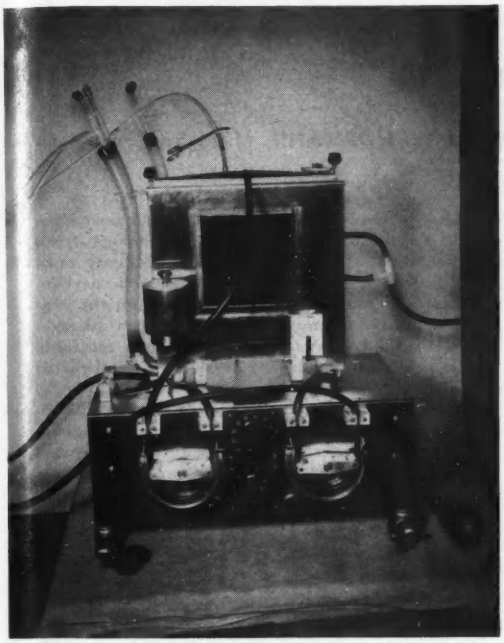

Figure 1.—Kay-Anderson heart-lung machine which consists of two roller pumps and a stationary screen oxygenator. Apparatus is compact and simple to use.

procedures on experimental animals, the heart-lung apparatus was used to by-pass the heart for periods of a half hour to an hour. All the procedures were successful and all the animals survived for long terms. The apparatus then was used clinically. The first procedure was performed on July 12, 1957. The patient was operated upon for a large atrial septal defect and possible ventricular septal defect, and a patent ductus arteriosus. Elective cardioplegia was used, potassium citrate being employed. After 32 minutes of open heart operation, using the heart-lung machine, the machine was stopped and the heart began to beat. However, an effective beat was never restored despite three hours of attempted resuscitation.

Thereupon, further experimentation was performed in the research laboratory and the heart-lung machine was greatly improved and simplified.* It can be sterilized by autoclave. On December 12, 1957, the improved apparatus was used for the first time in an operation on a human subject. The operation consisted of closure of a ventricular septal defect and the patient made an uneventful postoperative recovery. The next two patients, both operated upon for closure of a ventricular septal defect, also did well. In the next case the patient had an atrial septal defect and a ventricular septal defect. Both defects were closed very well. The pericardial sac was closed loosely with four interrupted sutures, as we had done in the previous patients. Postoperatively, the patient was alert and awake but the blood pressure was not adequate, which was believed to be owing to inadequate replacement of blood. Transfusion of blood did not bring about an increase in pressure, however, and the patient died 18 hours postoperatively. At postmortem examination it was observed that, although ample space had been left for blood to leak out of the pericardial sac, enough blood had remained in the sac to form a clot 2 cm. thick around the entire heart, which caused cardiac tamponade and resulted in low blood pressure. The atrial and the ventricular septal defects were both closed very snugly. The ventricular septal defect was located immediately beneath the aortic valve.

Between the foregoing case and the time this report was written, the Kay-Anderson heart-lung machine was used in six additional cases. One patient had a tetralogy of Fallot and a patent ductus arteriosus. The tetralogy of Fallot was completely cured by resecting the infundibular stenosis and suturing the ventricular septal defect. One of the six patients had an atrial septal defect and a valvular pulmonic stenosis. The atrial septal defect was closed and the valvular pulmonic stenosis was incised, under direct vision. The remaining four patients in the series had large ventricular septal defects, which were completely closed. One of these patients also had an anomalous left superior vena cava which drained into the coronary sinus. All of these last six patients have done very well.

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*Constructed for the authors by Corco, Inc., Los Angeles.

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Hepatocerebral Dysfunction

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• **The neurological manifestations associated with acquired liver disorders of various types may present difficult diagnostic problems until the condition is far advanced. Bizarre psychological and motor disorders occur when the central nervous system is affected by liver disease. The clinical features may in some ways resemble those of Wilson's disease, but such features as remitting coma, fetor hepaticus and seizures in "cholemia," and a Kaiser-Fleischer ring in hepatolenticular degeneration help to distinguish the two conditions. The biochemical abnormalities found in all types of hepatocerebral dysfunction may be quite similar one to another. While many studies suggest that the whole problem is simply the result of brain intoxication by a substance such as ammonia, other lines of evidence indict several factors in intermediate cerebral and liver metabolism. The treatment involves use of substances which may relieve certain blocks in biochemical processes, supplementary vitamins, low protein intake and strict avoidance of all neuro- and hepatotoxins.**

WHILE RECENT biochemical investigations have focussed attention on the liver in certain kinds of brain disorder, the relation between a sick liver and a sick brain is neither newly discovered nor at all specific. Cerebral dysfunction with liver disease has been described frequently ever since the time of Galen and the cerebral disorder is really not more unusual than that seen with certain diseases of the kidney, adrenals, or pancreas. What may be of some interest, however, is that certain heredofamilial liver and brain disorders may be closely mimicked by acquired conditions and that patients with unsuspected liver disease may present trying diagnostic problems in the neurological, medical, surgical or even psychiatric wards. Neither the venerable hepatocerebral decompensation now known as cholemia[10] or hepatic coma, nor the genetically influenced hepatolenticular degeneration of Wilson should present a difficult diagnostic problem when the condition is advanced; but less advanced stages, especially in the former disorder, may be misdiagnosed and mistreated unless the possibility of liver disease is entertained and explored.

The purpose of this paper is to describe the diffuse neurological manifestations of acquired liver disease and to enumerate some of the recent speculations as to etiology. Before proceding to a discussion of cholemia, however, a few words regarding familial hepatolenticular degeneration may be in order.

Around 1880 Homen[9] published reports of a family with cavitation in the lenticular nucleus, cirrhosis and bizarre motor disorders. Other similar reports followed rapidly and all observers were impressed with the clinical similarity that this condition bore to hysteria, which had just been defined at about that time. Westphal and Strümpell[20] then described chronic cases with the term *pseudosclerosis* because of its resemblance to multiple sclerosis. Fleischer[6] next described a pigmented ring at the corneoscleral junction in three cases of Westphal's pseudosclerosis, and Kaiser had previously described such a ring in what he thought to be multiple sclerosis. Wilson,[25] in 1912, combined all these factors, calling the syndrome *progressive hepatolenticular degeneration*, and he expressed belief that pseudosclerosis was but a variant of the picture. Later Denny-Brown[4] indicated that there was perhaps justification for distinguishing the two conditions, since pseudosclerosis tended to occur later in life and was of longer course. More recent pathological studies show clearly that the neurological lesions involve far more than simply the lenticular nucleus in both conditions. The genetic influence manifested in these cases seemed to set them sharply apart from the "cholemia" or hepatic coma known since ancient times and, in spite of many attempts to relate Wilson's disease to that seen with acquired liver failure, certain clinical signs may also allow for differentiation. Never has a Kaiser-Fleischer ring been observed in cholemia or hepatic coma. The tremor of hepatic coma is rarely if ever as severe as the violent intention tremor of Wilson's disease, and fetor hepaticus has not been reported in the latter condition. The difference in clinical features may be merely the result of quantity and duration, however, since many metabolic aberrations, including the metabolism of copper and nitrogen, are common to both.

Now, to return to a consideration of acquired liver and brain disease. It is clear that the condition has interested investigators in almost every branch

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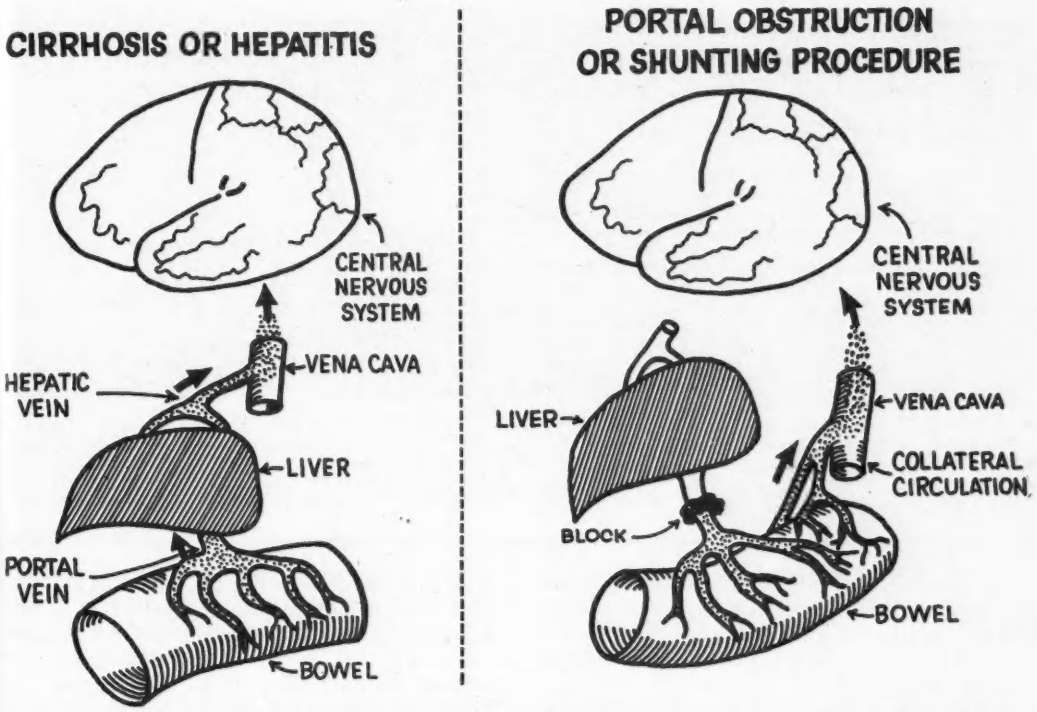

Figure 1.—*Left:* Portal flow normal but liver unable to detoxify or synthesize. In this type toxic amino acids from bowel, bilirubin, ammonia and abnormal amounts of porphyrins, iron and copper, as well as breakdown products from the liver, may reach the brain. Hepatic vein ammonia concentration may be higher than in portal vein.

Right: Liver function may be relatively good but portal flow blocked or shunted directly into systemic circuit. Ammonia from protein breakdown in bowel reaches brain in high concentration and liver may not receive basic material for essential enzyme or amino acid synthesis.

In either case, the permeability of the hematoencephalic barrier may be increased.

of medicine—the surgeon who has tried to ameliorate portal hypertension by means of a portacaval shunt, the internist who must treat chronic liver disease on the wards, the neurologist and psychiatrist who see the patient because of bizarre motor and behavior disorders (Figure 1).

The clinical features of hepatocerebral dysfunction find expression in both motor and mental changes of varying degrees. Unfortunately, one of the first manifestations attributed in humans to this sort of liver disease was coma, and for this reason the term "hepatic coma" came into wide use. Now there is no good term to describe the lesser degrees of affliction which may long precede the actual loss of consciousness. Perhaps the older term *cholemia* would do.

Cholemia has been extensively studied from a clinical as well as from a laboratory point of view and it now appears that one must consider everything from the most subtle of personality changes to gross confusion, from minor unsteadiness to severe ataxia, from slight tremulousness to coarse flapping of the extremities. The clinical picture is quite variable in the same patient at different times. For instance, long after the acute liver disease has subsided or long after the precipitating agent has started the train of events, the impairment of cerebral function, while showing exacerbations and remissions, is slowly and steadily progressive. In some patients neurological abnormalities may vary from day to day, or even from hour to hour, and this fact may indicate that the neurological disorder is not the result of a single simple biochemical abnormality but is the product of many complex variables. Frerichs[7] pointed out that with acute yellow atrophy of the liver one saw acute mania and convulsions, while with chronic cirrhosis, the pattern was one of quiet disorganization progressing to coma. It seems as though the condition might almost be self-perpetuating, since the progress is so relentless after the initial insult. In milder cases (or at least in cases of the more slowly progressing type) the first symptoms may be recurrent nightmares, aimless wanderings, loss of interest and drive, or even various psychotic manifestations. Often the patient seems alert and clear in the morn-

TABLE 1.—*Hepatocerebral Relations*

HEREDOFAMILIAL TYPES

(1) Hepatolenticular degeneration (Wilson's disease)

(2) Pseudosclerosis of Westphal and Strumpell

Tend to begin fairly early in life, characterized by progressive dementia and motor disorders. Intention tremor severe and motor activity does not cease at rest, though disappears during sleep. Kaiser-Fleischer ring present often in both types.

Chemical abnormalities consist of deficient formation of caeruloplasmin, decreased copper binding ability of serum, abnormal excretion of copper and alpha amino acids in no particular pattern. Kaiser-Fleischer ring contains copper, basal ganglia contain from four to fifteen times normal amounts of copper. Excretion of copper aided by B.A.L. Kaiser-Fleischer ring may blanch and patient may improve clinically.

ACQUIRED TYPES

(1) Secondary to intrinsic hepatic disease:
  (a) Cirrhosis:
    (1) Alcoholic
    (2) Dietary
    (3) Postinflammatory (hepatitis)
    (4) Toxic (hydrocarbons or halogenated compounds)

(2) Secondary to extrahepatic block or shunt:
  (a) Surgical:
    (1) Eck fistula
    (2) Portacaval anastomosis in humans
  (b) Nonsurgical:
    (1) Carcinoma of pancreas
    (2) Local metastases
    (3) Thrombosis of portal vein

POSSIBLE INTERMEDIATE CONDITIONS

(1) Copper poisoning
(2) Manganese poisoning
(3) Neurological changes in patients with chronic liver disease given NH_4 by mouth

ing, only to become confused later in the day. These changes occur long before jaundice or other overt signs of liver failure appear, and may be quite misleading. Another characteristic feature is a disorder of movement. This may take the form of mild ataxia or tremor at first, and may closely mimic cerebellar or basal ganglia disease. Close observation of the motor difficulty reveals that this too is quite intermittent and variable. One sees peculiar intermittent short movements like chorea, fluctuating rigidity, occasional flapping movements of the laterally held arms, and later, grimacing, sucking, reflex grasping, picking at the bed clothes. The muscle stretch reflexes are often increased for an hour or so, only to be normal at other times. Extensor toe signs are often noted and even convulsions may occur. Curiously, the neck is frequently stiff, making the diagnosis even more difficult. Once deep coma supervenes, the prognosis is poor for survival over two weeks.

An alert physician can be warned of impending hepatocerebral failure by the patient's description of curious visual hallucinations, slight changes in psychomotor activity, sudden onset of sphincter incontinence or stereotyped behavior. Another early complaint may be increased salivation, or a strange metallic taste in the mouth. Mild confusion is certainly a warning sign and it is important to recognize the difficulty, since administration of sedatives, especially barbiturates, may quickly precipitate fatal coma. As examples of the peculiar signs and symptoms observed in these patients, I might mention the patient with known liver failure who was found drinking his own urine, and another patient with "Banti's syndrome" who after a splenectomy began to do such things as putting her own child to bed on the ironing board and then forgetting about him. Because of the episodic behavior in the latter case, the patient was thought to have "psychomotor" seizures. Another case was seen in a man who had been deer hunting and who had eaten large quantities of venison. He was found in deep coma by his hunting partner on the next day.

Convulsions of all types may be seen in the same patient at different hours of the day, or one may note muscle twitchings closely resembling those of hypocalcemia or uremia. When the patient can cooperate and can hold his arms laterally the fingers are often seen to deviate laterally, to flex at the metacarpophalangeal joints while the wrist makes similar motions. With the patient supine and the leg elevated, sudden flexion at the hip or ankle, followed by slow return, may be observed. Similar movements may be seen in a protruded tongue or at the corners of the mouth; but one of the most interesting features, and one which seems to differentiate this condition from Wilson's disease, is that all the motions cease at rest and promptly disappear with the onset of coma. If the patient survives the coma, the movements may then reappear and remain for months or years. The limbs may be rigid and the face may show a "Parkinsonian" attitude. In one patient the dysarthria was so pronounced as to resemble that of acute alcoholic intoxication. The diagnosis was only suspected when, on getting close enough to the patient to examine eye grounds, the examiner noted a characteristic fetor hepaticus. This last feature, although frequently mentioned, is very difficult to describe. Perhaps the odor is comparable to that of decaying cantaloupe.

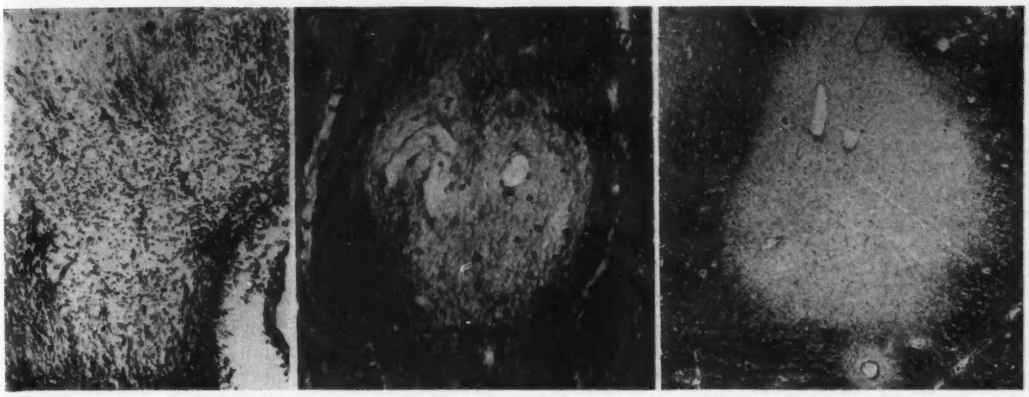

Figure 2.—*Left:* This is a large area of diffuse demyelination in brain tissue in a patient with uremia. There is a partial breakdown of the tissue resulting in some fragmentation. Weil stain. (×40.) *Center:* This small vessel shows a typical area of focal demyelination involving the white matter associated with hepatic disease. Weil stain. (×75.) *Right:* This is a large, sclerotic plaque situated within the brain of a patient with multiple sclerosis. There is a sharp demarcation between the injured and intact brain tissue. Note perivascular involvement. Azocarmine stain. (×40.)

This, then, is the clinical picture that results when a damaged liver affects the central nervous system. It is not precisely the same as the syndrome seen with familial liver and brain afflictions, and while the neurological manifestations of Wilson's disease are almost always accompanied by portal cirrhosis, hepatic coma or any of the other conditions mentioned above may result from a great variety of liver disorders (Table 1).

Unfortunately, neuropathologic examination adds very little to our understanding of either the familial or the acquired hepatocerebral syndrome. The astrocytic changes of Alzheimer, formerly thought specific for pseudosclerosis, and the neuronal changes seen in Wilson's disease are also found in patients dying with severe liver disease as well as in many other conditions. It is noteworthy, however, that the large multilobulated astrocytes described by Alzheimer are much more frequent in hepatocerebral disorders than they are in other conditions, but it is obviously difficult to explain the dementia and disorders of movement on the basis of glial changes of any sort. After fatal liver disease small areas of perivascular demyelination are often found in the brain, but these are quite indistinguishable from the changes seen, for example, in chronic uremia or recurrent hypoglycemia, and are not unlike the early changes of the primary demyelinating diseases (Figure 2). Neuronal changes are widespread in both the acquired and familial types of hepatocerebral disorder, and are quite nonspecific.

The biochemical approach to the problem was provided in 1858 by Frerichs[7] in a masterful analysis of clinical cases published in his treatise on liver diseases. He noted neurological manifestations in all cases of acute yellow atrophy and felt that hypoglycemia was the chief difficulty. He showed that bile itself was not responsible by giving the substance to dogs intravenously without producing neurologic symptoms. Later, when the Eck fistula was in use the animals were found to develop cerebral symptoms ("meat intoxication") on high protein diets. Attempts to produce the neurological symptoms by means of partial hepatectomy were inconclusive. In the 1920's manganese salts[5] had been found to damage both liver and brain, but no connection has since been established between manganese and the clinical syndromes associated with liver disease. More recently the administration of ammonium (NH_4) salts to people with severe liver disease has been found to produce neurological symptoms.[16]

The cumulative result of all these studies was that several schools of thought developed regarding the causes of the neurological disorder. In brief, one school believes that the difficulty arises from absorption of intestinal "toxins" which are allowed to bypass a damaged liver. Another theory is that the dying liver cells elaborate a neurotoxin. Still another group is of the opinion that the changes in the permeability of the hematoencephalic barrier play a dominant role; and lastly there is some evidence suggesting that the whole syndrome arises because of some changes in the metabolism of various dietary constituents after liver damage.

The derangement of nitrogen metabolism has received intensive study. Many investigators have concluded that because the ammonium ion is a toxic by-product of certain cerebral reactions and because the blood levels of ammonia may be elevated in severe liver disease, the problem is essentially one of ammonia intoxication.[10,16] The fact that many

other observers find no consistent correlation between cerebral symptomatology and blood ammonia levels indicates that the problem may be more extensive. Against the theory of ammonia intoxication the following observations may be cited: (1) First, venous samples are grossly inadequate since the muscles take up the majority of circulating ammonia, depending upon the arterial concentration.[1] (2) The venous blood ammonia levels do not correlate directly with the neurologic manifestations and, in fact, may be quite normal in deep coma. Likewise, slight elevations of ammonia may be associated with severe central nervous system symptoms. (3) The cerebral arterio-venous ammonia difference may be increased in hepatic coma, indicating that the central nervous system is taking up more of the compound than usual.[1] It seems unlikely that the brain would take up a neurotoxic agent in such quantities unless it were doing so as a secondary, or defense, reaction to some other chemical imbalance. (4) Very high blood ammonia levels have been produced without any neurological signs or symptoms.[19] (5) A concentration of ammonia much higher than any ever found in hepatic coma does not alter brain slice metabolism, while the same concentrations inhibit liver respirations by 20 per cent.[3] (6) Administration of ammonium salts or high protein diets may not produce neurological signs for several days, although the amount of ammonia in the blood goes up early.

This brief mention of a few isolated facts on the subject certainly does little justice to the tremendous amount of work that has been done, but space does not permit detailed arguments and there are other studies which deserve mention.

Another possible cause for the cerebral dysfunction might be found in the metabolism of the alpha amino acids. From the wealth of data pertaining to these compounds the most important facts to emerge are that: (1) Glutamine⇌glutamic acid⇌alpha ketoglutaric acid+NH_3. (2) Methionine is a potent inhibitor of the foregoing conversion from glutamic acid to glutamine.[22] (3) Glutamic acid and methionine are both elevated in the serum of patients with acquired liver disease and both, because of their anti-metabolic effects on glutamine, are capable of producing severe metabolic disturbances within the central nervous system.[23] (4) Administration of methionine in both acute and chronic liver disorders may precipitate coma quite as dramatically as any of the other agents that have been implicated. (5) Deranged metabolism of methionine in the liver itself may lead to the increase in circulating ammonia.[18]

Disturbances in copper metabolism are also common to both the familial and acquired types of hepatocerebral disorders. In acquired liver disease the hepatic concentration of copper may be greatly increased. In 1920 it was found that the administration of copper produced cirrhosis, and in 1930 copper deficiency in animals was found to result in ataxia and demyelination of the cord. Later it was found in humans that gross cavitation of the brain may occur with acute copper poisoning.[3] In patients dying of hepatic coma the copper content of the basal ganglia is said to be significantly elevated, as it is in Wilson's disease. It has been stated by previous observers that in cholemia, unlike Wilson's disease, copper excretion is not elevated; but in one of the cases observed by the author the urinary excretion of copper was four times normal in 24 hours. One cannot clearly indict copper as the sole cause of the neurological manifestations, however, since copper has a reciprocal relationship with iron and may act by displacing something else.

Since the features of hemochromatosis may be quite like those of Wilson's disease, one must consider also the possible role of iron in hepatocerebral dysfunction. Intravenous iron preparations in humans have caused both coma and seizures[3]; in hemochromatosis the deposition of hemosiderin leads to pronounced changes in both glia and neurones; and in hepatitis the serum iron is elevated.

Carbohydrate metabolism, the main source of energy for the central nervous system, is decidedly affected by liver disease. Depletion of the four carbon acids within the neurones cannot be easily corrected in liver disease because of lack of essential vitamins and enzymes manufactured by the liver. Since some brain glycolysis is anaerobic, lactic acid is a by-product. In liver disease the lactic acid levels which may develop are easily neurotoxic.

Abnormalities in porphyrin metabolism, well known in liver disease, may also play a part in hepatocerebral disorders of all types, since oxygen is brought to the brain not only by hemoglobin but also by cytochrome, an iron-containing porphyrin. Certain types of porphyrins are certainly very toxic to the central nervous system, but others are essential; and in one of the cases observed by the author the porphyrin output was depressed during coma but rose during lucid intervals.[15]

Another interesting possibility in both acquired and hereditary hepatocerebral disorders is that in neither is the blood brain barrier operating normally. Himwich[8] showed that hepatectomy considerably increased the permeability and that brain changes may result from admission of normal metabolites that are usually kept out. Injecting liver extract restores the situation to normal for a time.

A recent study indicated that a damaged liver

may not supply certain essentials for the maintenance of normal brain function. It has been shown that the brain requires a certain amount of serotonin and since the liver is responsible for the conversion and transport of certain serotonin precursors, the brain may suffer after liver damage by virtue of an actual metabolic deficiency, rather than an excess of some circulating substance.[2]

These brief references to the vast amount of work pertaining to hepatocerebral dysfunction will certainly not provide a suitable answer to the problem. A review of essential data, however, may facilitate the management of patients with such conditions. The patient with known cardiac decompensation and liver congestion who seems to become confused after the administration of ammonium chloride or ammonium-containing resins will certainly not be treated with barbiturates or other sedatives if the possibility of an incipient hepatic coma is borne in mind. Likewise, the patient with known portal hypertension who has been treated surgically with portacaval anastomosis will certainly not be given a high protein diet or narcotics postoperatively. Whereas the so-called "lipotropic" agents such as methionine used to be given frequently in certain inflammatory liver diseases, the contraindications to the use of these drugs will now be obvious. When a patient with known esophageal varices is suddenly found near coma with a flapping tremor of the extremities and fetor hepaticus, it will be easy to see why removal of the large amount of blood from the ruptured varix will correct the tendency for large amounts of nitrogenous material to be absorbed from the gastrointestinal tract. Sometimes a cleansing enema in these patients is dramatically restorative. Lastly, a patient in whom affective or behavior disorders develop after hepatitis may not respond as well to psychotherapy as he will to changes in diet or other medical measures.

Once cholemia has been diagnosed and is seen to be far advanced, there is frequently little that can be done. However, the administration of antibiotics to remove the urea-splitting organisms from the gastrointestinal tract, the administration of large amounts of the water-soluble vitamins, the scrupulous maintenance of fluid and electrolyte balance, and the administration of such agents as glutamic acid or arginine may be of some help. The clinical syndrome seems to be reversible in a fair number of cases, provided the pathologic condition in the liver is not neoplastic or rapidly progressive. In a rare case it might be possible to use the artificial kidney to dialyze the patient's blood, as is done in certain acute toxic nephropathies.

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Endothelial Cells in Blood Smears

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• **Smears of blood obtained by venipuncture sometimes contain odd looking cells which occur singly and in sheets. Their presence may suggest a possible diagnosis of infectious mononucleosis, leukemia, or even malignant disease. Actually, they are endothelial cells from the lining of blood vessels. Use of a barbed needle for venipuncture is the cause of such artifacts.**

THE CHANCE OCCURRENCE of endothelial cells in blood smears may give rise to erroneous diagnosis. Appearing singly, these cells may simulate abnormal monocytoid cells of infectious mononucleosis, acute lymphocytic leukemia or monocytic leukemia. Appearing in sheets, they may simulate metastasizing malignant cells. The purpose of this communication is to emphasize the necessity for recognizing these cells.

Recently we examined a smear made from antecubital venous blood drawn from a patient who was convalescing from an abdominal-perineal resection for adenocarcinoma of the rectosigmoid colon. (The surgical specimen showed neoplastic invasion to the serosal surface but no extension to the surgical margins, no involvement of lymph nodes and no invasion of blood vessels.) The blood smear contained large numbers of unusual cells occurring singly and in sheets (Figures 1 and 2). These cells varied from 20 to 30 micra in size, were elongate, tended to be polygonal in outline and had more or less distinct borders. With Wright's stain the cytoplasm was pale blue and occasionally contained fine granules or clear vacuoles. The nuclei were red-purple, oval, and varied in size from 12 to 18 micra. The chromatin net was moderately coarse, and from one to three pale blue nucleoli were present. Cells of this description were found only in the one smear; none were seen in subsequent preparations.

These cells were thought to be of endothelial origin and to derive from the site of venipuncture. However, it was tempting to assume that they represented metastatic tumor, although the passage of sheets as large as these through capillary beds seemed unlikely. For comparison, touch preparations of vein endothelium obtained at a necropsy were stained by Wright's method. Cells identical with those in the blood smear were found in large numbers (Figure 3).

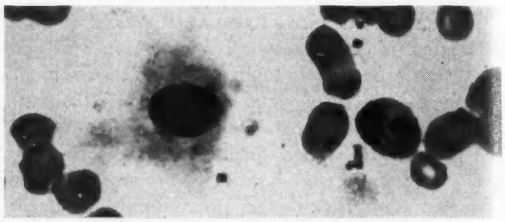

Figure 1.—Single endothelial cell (×690).

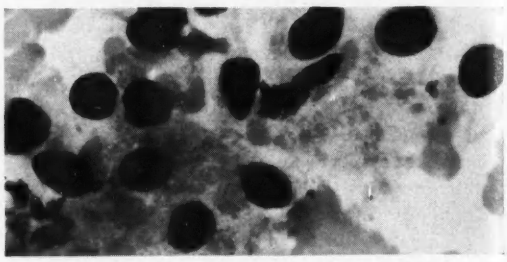

Figure 2.—Sheet of endothelial cells (×690).

Figure 3.—Touch preparation of vein endothelium from necropsy (×690).

Shanberge[1] reported similar experience with endothelial cells accidentally appearing in blood smears and gave convincing evidence that they may occur incident to the use of barbed needles for venipuncture.

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This study was supported in part by funds from the Peninsula Memorial Blood Bank, Burlingame.

Dr. Wellings is a senior research fellow, United States Public Health Service.

Submitted January 14, 1958.

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Laboratory Diagnosis of Typhoid Fever

With Notes on Treatment

ALBERT G. BOWER, M.D., Los Angeles

• **As indicated by a study of 41 cases of typhoid fever treated in three years, blood culture alone is often sufficient for the diagnosis of the disease if a large (30 cc.) specimen is used. Demonstration of the organism is the only completely diagnostic measure, but this was also achieved by the Widal reaction, by fecal or urine culture, or by aspirated bile culture, which in one case gave the only positive response.**

Chloramphenicol is the drug of choice in treating typhoid fever. Since only 25 per cent of patients develop immunity, immunizing injections should be started a week after therapy is discontinued.

TYPHOID FEVER is so rare in most large cities of the United States, where medical teaching is centered, that many physicians complete their internship and residency training without ever having seen a case of the disease. They are therefore not "typhoid-conscious" and do not consider this possibility in differential diagnosis. At the Los Angeles County General Hospital there are about 15 cases a year. Most of these are incurred abroad, for although the United States Public Health Service advises immunization against many other diseases for citizens leaving the country, typhoid fever immunization is regrettably not included.

Clinical signs and symptoms of typhoid fever have been described many times and are helpful in diagnosis, but the purpose of this presentation is to emphasize that even when these findings are typical, the only measure which establishes the diagnosis is the isolation of the infecting organism from the blood. Usually it is present in the blood during the first week, but experience of 35 years indicates that some degree of bacteremia persists from onset to final defervescence. As the factors of immunity come into play, more particularly in the second week, the reticuloendothelial fixed-tissue phagocytes are stimulated to a maximum, and the spleen and liver (which become perceptibly enlarged) take up large numbers of the bacteria; therefore fewer and fewer are present in the blood. This sequence of events must be taken into consideration in obtaining a positive response to blood culture.

It is unusual for the Widal agglutination test to give a positive response before the second week. In the author's experience the positive response may be delayed until the sixteenth week and in many cases it is never obtained, as this presentation reports.

The following resume of 41 cases of typhoid fever, observed at the Los Angeles County General Hospital between June 1, 1953, and May 15, 1956, exemplifies the diagnostic laboratory methods employed in the communicable disease unit of the hospital:*

Chief Physician, Communicable Disease Service, Los Angeles County General Hospital, Los Angeles.

Submitted February 25, 1958.

*All laboratory procedures are done under the direction of Jean W. Dedrick, Ph.D., director of the communicable disease laboratory.

Blood Culture: Approximately 10 cc. of blood is added aseptically to 100 cc. of tryptose phosphate broth and a second 10 cc. of blood to 100 cc. of bile broth. If no growth occurs in either medium, a second culture is made of 30 cc. of blood added to 300 cc. of bile broth. If growth of Gram-negative bacilli occurs, the organisms are tested for motility and identified biochemically. Specific antisera are used for final identification; the organisms being tested against Kauffmann-White Group D, flagellar H and Vi antisera. When agglutination is produced, the organism is identified as *S. typhosa.* Since there are far fewer bacteria in the blood after the first week of the disease, the use of larger (30 cc.) blood specimens is logical, and is validated by the high frequency of positive response—29 out of 41 cases, in the present series, a higher proportion of diagnosis than was obtained by any other method.

Fecal Culture: Rectal swabs are placed in sterile normal saline solution. About 1 gram of feces is suspended in 5 cc. of saline solution. A loopful of the resulting suspension from each is then streaked on Shigella-Salmonella agar. Nonlactose-fermenting colonies are identified as described under blood culture.

Urine Culture: After the second week, should the disease run that long under modern therapy, it is quite common to find typhoid bacilli present in the urine. In such cases, approximately 10 cc. of urine is centrifuged at 3,000 revolutions per minute for 15 minutes and the resulting sediment is cultured

TABLE 1.—*Diagnostic Criteria In 41 Cases of Typhoid Fever*

Diagnostic Tests	Number Positive	Basis of Diagnosis
Blood culture	6	On blood culture alone. Widal reaction was negative.
Widal reaction	4	On this reaction alone.
Widal reaction and blood culture	20	Based on the two tests alone.
Stool culture and blood culture or Widal reaction (or both)	18	Only in one case was the diagnosis made by fecal culture alone.
Bile culture	5	In one case, there was no other diagnostic response.
Urine culture	2	Both cases also diagnosed by blood culture and Widal reaction.

on Shigella-Salmonella and eosin-methylene blue agar and in tryptose broth. Nonlactose fermenters are identified as above.

Widal Reaction: The patient's serum is inactivated at 56°C. for 30 minutes. Twofold serial dilutions of serum ranging from 1:40 to 1:5,120 are then made in normal saline solution in 0.5 cc. amounts. Then 0.5 cc. of antigen is added to each tube, giving final dilutions of 1:80 through 1:10,240. A control tube containing 0.5 cc. of saline solution and 0.5 cc. of antigen is included. The tubes are then incubated at 37°C. for 20 minutes, centrifuged at 2,000 r.p.m. for ten minutes, and read for agglutination. The last dilution in each agglutination which occurs is reported as the titer. The antigen is the typhoid "H" antigen and is supplied by the California State Department of Public Health Division of Laboratories.

In regard to the Widal test, it should be remembered that in some cases of typhoid fever, "H" (flagellar) agglutinins do not develop in the blood, while "O" (somatic) agglutinins may be present in relatively high titer. Also, the proportion of cases in which "O" agglutinins develop is much higher (we do not know why) in some communities than in others. Felix and Pitt[1] explained why many virulent strains of typhoid fever do not agglutinate with an "O" antigen: They demonstrated the presence of another special antigen, the "Vi" antigen, as Felix named it. Because the "Vi" antigen is heat-labile, Widal tests cannot detect it unless made with living suspensions of the typhoid organism at 37°C. It is destroyed by being heated to 60°C. for one-half hour, or 100°C. for five minutes. Weak solutions of phenol also destroy it. The presence in a patient's blood of the "Vi" antigen is generally considered *prima facie* evidence of the presence of typhoid fever, whereas the presence of "O" and the "H" antigens may be due to previous vaccination against typhoid fever, to anamnestic reactions or to the Hektoen phenomenon when actually typhoid fever is absent.

The Hektoen phenomenon is one in which a disease other than typhoid fever gives rise to a heightened Widal reaction against ordinary typhoid antigens, the specific agglutination being higher, however, against the organism causing the other disease than it is against typhoid fever.

DISCUSSION

Of the 41 cases covered by this report, the diagnosis in six was made on the basis of blood culture alone, no Widal reaction being evoked (Table 1). Only four were diagnosed on the basis of the Widal reaction alone. In 20 cases, both tests gave a positive response. Fecal culture was the only positive test finding in a single case; in 18 others, it was confirmed by blood culture or Widal reaction or both. The same was true of aspirated bile culture, which gave the only positive response in one case and was confirmed by other tests in five others. Positive urine culture in two cases was otherwise confirmed in both.

NOTES ON TREATMENT

At present, one drug stands out above all others in the treatment of typhoid fever—chloramphenicol. The dosage is most important: In each 24-hour period, 65 mg. per kilogram of body weight for an adult patient and 120 mg. per kilogram for a child. Cures have been reported with smaller doses for children, according to Young's rule, but I have been unable to duplicate these results. In my experience, without the larger dosage for children the disease runs its usual course.

Although chloramphenicol has been incriminated as the cause of malignant neutropenia in some persons, it appears to contribute only rarely to that suppression of hemopoiesis which frequently occurs in typhoid fever and gives rise to leukopenia.

Other drugs have been mentioned in the literature as equally efficient, but the fact that they are neither available nor discussed any longer in the literature makes one doubt their efficacy. At any rate, chloramphenicol is the drug of choice at this moment. It apparently is not bactericidal but bacteriostatic, and one-fourth of all patients in whom the disease

has been brought under control and who have become defervescent by the use of chloramphenicol, will have typhoid fever again at a later date, varying from a few weeks to several months, unless they are vaccinated with typhoid vaccine after they apparently have been cured by chloramphenicol. This drug definitely interferes with the function of immunity.

It has become fashionable to add steroids, particularly cortisone, to the treatment of typhoid fever. Since these drugs also interfere with the mechanism of immunity, it is not wise to employ them routinely in the treatment of typhoid fever when chloramphenicol alone is so efficient.

The temperature and the course of the disease are usually halted within five days after chloramphenicol therapy is begun. However, when this therapy is started late, it will not prevent the usual complications or sequelae, such as hemorrhage or perforation.

At the conclusion of typhoid therapy, because 25 per cent of patients have not developed immunity, I usually allow patients to remain without treatment for five days to a week and then immunize them with killed typhoid vaccine. From experience, I believe that vaccination is more efficient in the prevention of typhoid recurrences or relapses if the three-dose method of immunization used by the armed services is employed; namely, the use of 500 million killed typhoid organisms for the first vaccine dose, and one billion at each of the two succeeding doses, each given a week apart. At present, there is a tendency to make all three doses the same, each containing only 500 million organisms. The stronger doses, in my opinion, will prevent some of the relapses that still occur while vaccination is being carried out or immediately thereafter.

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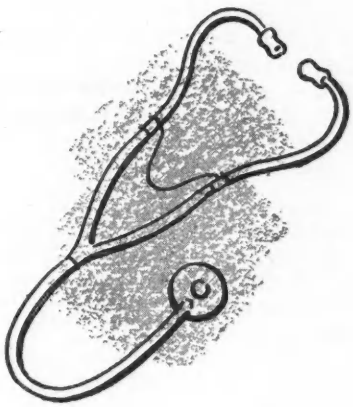

Child Pedestrian Fatalities in Los Angeles

PHYLLIS M. WRIGHT, M.D., Los Angeles

• In an analysis of information concerning 81 child pedestrians killed in traffic accidents in the city of Los Angeles during a recent five-year period it was observed that the majority of children were preschoolers playing near their residences but without adult supervision. In most instances the action of the child and not the driver of the vehicle was responsible for the accident. Among school age child fatalities, improper handling of a bicycle was commonly to blame.

THE PROBLEM of childhood accidents, although receiving increased attention, is far from solved. In a recent period of one year, admissions due to accidents made up 16 per cent of all admissions to the pediatric wards of a general hospital in Los Angeles. Most of these children had been injured in traffic accidents.

A particularly tragic group of traffic accidents is composed of injuries to child pedestrians. With an eye toward development of better preventive methods, the Bureau of Maternal and Child Health of the Health Department of the State of California decided to investigate this particular problem.

With the cooperation of the Traffic Services Division of the Los Angeles City Police Department and the Coroner's Office of Los Angeles County, a survey was undertaken of the case histories of child pedestrians who died in traffic accidents within Los Angeles City limits during the years 1952 through 1955. During this four-year period there were 12,902 pedestrians of all ages involved in traffic accidents, of which 4 per cent or 563 ended fatally.[1] Eighty-five of those who died were children aged 14 years and under (see Table 1).

Case records of 81 of the 85 child pedestrians (bicyclists also included) obtained from the police files were reviewed in an attempt to clarify the circumstances of the accidents. Data available from the records included information obtained by the investigating police officer at the scene of the accident, with statements of the participants and witnesses, a scaled diagram of the location, a description of pedestrian action, driver action, driver violation, sobriety of driver, traffic control, weather, lighting, vehicle condition, vision obscurement and character of the road. Also included was the result of the coroner's inquest, if any, with the decision of the coroner's jury as to whether the driver of the car was believed to be criminally responsible, and a statement as to the final disposition of the case.

TABLE 1.—*Pedestrian Accidents in Los Angeles City*

	1952	1953	1954	1955	Totals
Injured—all ages	3,285	3,317	3,133	3,167	12,902
Deaths—all ages	140	128	142	153	563
Deaths—0 to 14 years	25	14	26	20	85
Bicycle rider deaths—(0 to 14 years)	3	2	5	5	15

TABLE 2.—*Kind of District in Which Traffic Accidents Fatal to Pedestrian Children Occurred*

		No. Cases
Residential		53
Business—shopping		18
Industry—manufacturing		2
Country		4
School		1
Multiple dwelling		1
Other		2
Total		81
Parking lot	3	
Sidewalk, yard or driveway	9	
Total	12	

Age of Victims

The problem of child pedestrian fatalities appears to be largely concerned with preschool and early elementary school-aged children. There were over twice as many fatalities in the group age 6 years and under as in the group 7 to 14 years of age. Fifteen of the older age group were bicyclists.

Sex of Victims

Boys were involved in fatal accidents almost twice as frequently as girls, a fact which is in agreement with data observed in other surveys.

Type of District

Fifty-three fatal accidents occurred in residential areas as compared with 20 in business, shopping and industrial areas (Table 2). Only one death occurred

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Submitted October 30, 1957.

TABLE 3.—*Time of Day Traffic Accidents Fatal to Pedestrian Children Occurred*

	No. Cases		No. Cases
LIGHT		DARK	
8 a.m.	5	5 p.m.	4
9 a.m.	1	6 p.m.	5
10 a.m.	7	7 p.m.	4
11 a.m.	3	8 p.m.	2
Noon	5	9 p.m.	1
1 p.m.	4	10 p.m.	0
2 p.m.	10	11 p.m.	1
3 p.m.	14		—
4 p.m.	4	Total	17
5 p.m.	11		
	—		
Total	64		

TABLE 4.—*Data on Supervision of Pedestrian Children Killed in Traffic Accidents*

	No. Cases	
Alone	35	(17 were under 5 years)
With parent(s)	15	
With other adult	5	
With other children	25	

in the vicinity of a school, the area in which there is the greatest concentration of children during certain periods of the day. Twelve children were killed in areas which might normally be thought to afford some protection—for example, sidewalks, yards or driveways.

Time of Day

The majority of accidents occurred during the daylight hours when children are most likely to be at risk on the street (Table 3).

Supervision of Child

From an analysis of the witness reports, it was possible to determine who was with the child at the time of the accident. Thirty-five of the children, 17 of them in the age group 1 to 4 years, were believed to have been alone at the time of the accident. Twenty children were with their parents or another adult and 25 were with other children (Table 4).

Primary Cause of Accident

It was possible on the basis of the police reports to divide the accidents roughly into two types—one in which the action of the driver was primarily responsible for the fatality, and another in which the pedestrian action was primarily responsible (Table 5). In only 23 of the 81 cases was the driver responsible. Reckless or inexpert driving, excessive speed, backing carelessly, defective vehicle and violation of pedestrian right-of-way in a cross-walk were primary causes of only a small group of fatalities. The child was at fault in the majority of accidents, either running into the street (often darting from between parked cars), crossing carelessly, playing in the street or riding a bicycle carelessly. It was of interest that in every instance of a bicycle fatality the child was at fault, either due to inexpert handling of the bicycle, "riding double," not stopping at a boulevard stop or speeding out of an alley onto a busy street.

TABLE 5.—*Primary Cause of Vehicular Accidents in Which Pedestrian Children Were Killed*

	No. Cases
Driver action:	
Reckless or inexpert driving	7
Excessive speed	4
Backing carelessly	4
Defective vehicle	3
Violation of pedestrian right of way	3
Runaway vehicle	2
	—
Total	23
Pedestrian action:	
Running into street	26
Crossing carelessly	9
Playing in street	5
Riding bike carelessly	11
	—
Total	51

TABLE 6.—*Data on Age, Sex and Responsibility of Driver in Cases of Pedestrian Children Killed in Vehicular Accidents*

Age of Driver	Male	Female	Criminally Responsible
0 to 10 years	2	....	....
11 to 20 years	10	1	2
21 to 30 years	19	6	3
31 to 40 years	17	6	2
41 to 50 years	9	....	1
51 to 60 years	5	2	1
61 to 70 years	3	1	2
	—	—	—
Totals	65	16	11

Information Concerning the Drivers

Most of the drivers of vehicles involved in fatal child pedestrian accidents were young people (Table 6). They were in their teens, twenties, and thirties—at an age when reflexes and visual acuity might be expected to be at the optimum. There were three children drivers under the legal age limit even for learner's permits. One 13-year-old girl struck and killed a child while driving her mother to the market. She habitually drove the family car because the mother was not able to get a driver's license. Another 8-year-old struck and killed his own brother while being instructed by his father in the handling of a car. In only one case was there a statement that the driver had been drinking and was under the influence of alcohol. The fact that there were 65 male

TABLE 7.—*Data on Type of Vehicle Involved in Accidents Fatal to Pedestrian Children*

	No. Cases
Passenger car	62
Truck	17
Bus	1
Motorcycle	1
Total	81

drivers and 16 female drivers involved in fatal pedestrian accidents can only be interpreted in the light of the proportionately greater total number of male driving hours.

In the opinion of the investigating police officers and the coroner's jury, only 11 drivers were held criminally responsible and therefore subject to legal prosecution for felony or misdemeanor. In ten additional cases the driver was primarily at fault but circumstances were such that no definite legal action was indicated.

Type of Vehicle

Most of the vehicles were postwar passenger cars in relatively good operating condition. Three cars, however, had defective brakes or defective steering gear, and one of these was a typical "hot rod." Seventeen were trucks, of which approximately half were delivery trucks being driven in residential areas (Table 7).

Reactions of Driver

Statements of the drivers and witnesses were reviewed to determine the reactions of the driver (Table 8). Half of the drivers saw the children but were unable to stop before hitting them. In 33 instances the drivers did not see the children at any time but were aware of a thumping sensation. One driver thought that he had run over a box in the road and would have continued on his way without stopping except that a passenger riding in his car looked back and saw the injured child. Three drivers left the scene of the accident without being aware that anything had happened and would have been considered as hit-and-run drivers had they not been flagged down by witnesses and then immediately returned to render assistance. There were three actual hit-and-run drivers, two of whom were apprehended later by the police.

Relationship to Vehicle Speed

From the statements of the drivers and the witnesses, an approximation of the vehicle speed immediately preceding the accident was obtained. In some cases, measurement of skid marks, examination of brakes and other methods were employed by the police department to estimate vehicle speed. It can

TABLE 8.—*Reactions of Driver in Accidents Fatal to Pedestrian Children*

	No. Cases
Saw child but could not stop	42
Didn't see child, felt thump	30
Didn't know had hit child	3
Hit-and-run	3
Miscellaneous	3
Total	81

TABLE 9.—*Vehicle Speed in Accidents Fatal to Pedestrian Children*

Vehicle Speeds (Miles per Hour)	No. of Vehicles
0 to 10	25
11 to 20	19
21 to 30	17
31 to 40	9
41 to 50	5
51 to 60	1
	76

TABLE 10.—*Time of Death, After Accident, of Children Fatally Injured by Vehicles*

	No. Cases
Died immediately	17
Survival time of others:	
0 to 1 hour	31
1 to 8 hours	20
8 to 24 hours	9
1 to 7 days	3
Over 7 days	1
Total	81

be seen in Table 9 that most of the vehicles were moving at a speed of under 30 miles an hour at the time of the accident.

Survival Following the Accident

Forty-eight of the 81 children died either instantly or within an hour after the accident, and therefore before adequate definitive medical and surgical treatment could be started. Twenty children lived from one to eight hours after injury. Nine lived from eight to 24 hours and only four children for more than 24 hours (see Table 10).

Cause of Death

The results of the coroner's investigations revealed that cerebral injury was the cause of death in 45 of the cases; cervical cord injury in three of the cases; crushing injuries of the chest in three and of the abdomen in nine. Multiple injuries were listed as the cause of death in 21 cases (see Table 11).

TABLE 11.—*Cause of Death in Vehicular Accidents Fatal to Pedestrian Children*

	No. Cases
Cerebral injury	45
Cervical cord injury	3
Crushing of chest injuries	3
Abdominal injuries	9
Multiple injuries	21
Total	81

DISCUSSION

From the foregoing data it appears that the typical child pedestrian killed in a vehicular accident is not, as might be supposed, the victim of a speeding or intoxicated driver. Rather, he is a small child, often of preschool age, who while playing without adequate supervision in front of his home, darts into the path of a moving vehicle. He is often not observed by the driver of the car, perhaps because of his size. Usually he dies of a head injury before adequate medical and surgical treatment can be instituted.

From these data it is apparent that better traffic engineering, more traffic lights and stop signs, or better enforcement of existing traffic laws, will not provide the answer to the problem of child pedestrian fatalities. Perhaps the greatest inroads into the problem will be made by an education program beginning in the Well Baby Clinics and the pediatricians' offices and carried over into the school years by parent-teacher groups.

The fact that so few accidents now occur in the neighborhood of schools does not mean the problem of traffic accidents has been solved by the present traffic control methods in these locations. Rather it may mean that, in concentrating on devices such as yellow cross walks, stop signs and crossing guards, we may be creating a false sense of security in the child who is thus taught to believe that he may enter and cross safely in any crosswalk without exercising due caution in looking for oncoming cars. In other words, his school crossing experiences have been made artificially safe by intensive efforts on the part of the PTA, and he does not learn self-reliance and the general principle of "look before you leap."

Intensive efforts should be made to educate children in the proper control of bicycles. Children cyclists must be taught to observe traffic regulations, and in no instance should "riding double" be permitted.

In city planning attention should be given to adequate backyard and traffic-free playground areas for children; also to laying sidewalks in new areas where they are now sometimes omitted. The current trend in new Los Angeles subdivisions toward "country estates" on small lots without sidewalks is deplorable, for children must walk in the roadway to visit their playmates.

In the smaller group of accidents in which the driver is primarily to blame, better traffic law enforcement, stiffer penalties, and an increasing program of driver education is indicated.

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ACKNOWLEDGMENTS

This study was supported by a grant from the Division of Maternal and Child Health of the Health Department of the State of California. The author wishes to express appreciation for the cooperation of the Los Angeles City Police Department, Traffic Services Division and the Office of the Coroner of Los Angeles County.

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Social Security Footnotes

AMERICAN MEDICINE would do well to study the plight of physicians in Britain and France before accepting financial arrangements that would make them sitting ducks for capture by government.

—*From the Department of Public Relations, American Medical Association*

The Controversial Ovary

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• **Routine removal of ovaries at hysterectomy has been urged as a means of preventing ovarian carcinoma. Proponents of this policy, however, have not submitted the crucial datum: What proportion of women undergoing hysterectomy for benign conditions will later have ovarian carcinoma if the ovaries are not removed. Granting that oophorectomy will effectively prevent ovarian carcinoma, it creates an endocrine imbalance that cannot be corrected artificially, and the lack of ovarian hormones may precipitate osteoporosis or cardiovascular disease. If the ovaries appear normal, if there is no history of carcinoma, and if the patient understands and accepts the risk, the ovaries usually can be conserved at hysterectomy for benign conditions.**

THE QUESTION of whether or not to remove normal ovaries at the time of hysterectomy for a benign uterine lesion revolves mainly about our fear of the possible future development of carcinoma of the ovary. While the incidence of ovarian carcinoma is less than in either the corpus or the cervix, it does occur with sufficient frequency and insidiousness, and with so unfavorable a prognosis, that there would appear to be some justification for oophorectomy in such opportune circumstances as when the uterus is to be removed.

Certainly in young women this additional procedure is generally not acceptable or advisable, but during the climacteric when the ovaries appear to be functionally on the wane there would seem to be some merit in removing them. If, in fact, ovarian function is absent or short-lived after hysterectomy, then there can be no doubt as to the advisability of simultaneously removing both ovaries. In a given case physicians are usually guided, first, by the statistical evidence as to the incidence and likelihood of carcinoma developing in such ovaries, and second, by personal prejudices. These are usually based upon a limited experience, for not many physicians see enough cases of ovarian carcinoma to formulate well-founded and definitive conclusions. Probably almost anyone who has seen ovarian cancer in patients who have had hysterectomy, patients who would probably have been spared this fate if the ovaries had been removed at the same operation, would be easily convinced that oophorectomy is advisable.

The statistical data on the subject are in many respects confusing and subject to misinterpretation. The death rate for carcinoma of the ovary is 16 to 25 per 100,000 in women between the ages of 45 and 64, according to the 1956 published reports of the Metropolitan Life Insurance Company. These data reasonably accord with those cited by Hollenbeck[5] and Randall.[7] Several reports[2,3] indicate that approximately 3 per cent of patients have had operations at which oophorectomy, had it been done, might have prevented the disease. Some investigators regard this as a significant figure and consequently favor routine removal of ovaries incidental to hysterectomy.

Submitted January 2, 1958.

A comparison of current statistics[1,3,7] suggests several things. First, carcinoma of the ovary appears to be significantly more frequent in women who have had previous pelvic operations for benign lesions than in other women of the same age. Second, there is an obvious disparity between probability,[1] incidence[5] and actual mortality rates for ovarian carcinoma[8]; and third, the interpretations indicate certain fallacies in the application of statistics to medical management.

With a death rate about 20 per 100,000 in women between 45 and 64 years of age,[6] we would theoretically prevent something less than two cases of ovarian carcinoma for every 10,000 operations if all of this age were castrated. In one report it is stated,[3] "Yet the fact remains that the incidence of patients in the combined series (2,097 cases) who developed carcinoma after having had initial surgery at the age of 40 or over shows an over-all rate of 3.05 per cent. Is this a significant figure? We are of the opinion that it is."

To say that 3 per cent of women with ovarian cancer have had operations at which oophorectomy would have eliminated the disease, is not the same as saying that 3 per cent of women with hysterectomy will have cancer of the ovary; yet that appears to be the implication in this and similar discussions. If this is not the implication, then the 3 per cent figure loses much of its significance. None of the reports, in fact, state the overall number of women who have had hysterectomy, nor do they list the indications for the operation. While this is obviously difficult to do, nevertheless it is

pertinent to any evaluation of the subsequent risk of carcinoma of the ovaries and the advisability of removing them. If this figure is significant as is implied—if ovarian carcinoma is materially more frequent in women who have undergone hysterectomy—then it must be considered that in these women the removal of the uterus may have contributed to subsequent pathological changes in the ovary. Then, further, the conditions which produced the initial benign uterine lesion may have continued to act unfavorably on the ovaries, or on the other hand uterine activity before hysterectomy may have inhibited ovarian disease which afterward could proceed unchecked.

Obviously, then, this statistical information is not too helpful in deciding whether or not ovaries should be removed at the time of hysterectomy. As a prophylactic measure there can be no question that removal of them will usually prevent ovarian cancer; but whether by removing normal ovaries some other metabolic disease may be precipitated is a matter which must also be considered. We may tend to overlook or ignore the effects of this procedure which manifest themselves in other than the gynecological domain.

I am sure that because of personal experiences, bias or conviction, many surgeons will continue to remove ovaries at the time of operation in women beyond a certain age—drawing the line at 40 years, 45 years, or the menopause. Such arbitrary division is based on the false assumption that chronological age is synonymous with physiological age. The more conservative surgeons may remove one ovary only, in the belief that they are thus reducing the risk of carcinoma by 50 per cent. But very often the wrong ovary might be removed. The ovary with greater function may be enlarged by a corpus luteum or some such physiologic cause indicative of usefulness but may, to the inexperienced, appear to be the one most likely to give trouble, and therefore be removed. Frequently the smaller, corrugated, atrophic-looking ovary with no evidence of recent activity is the one that is left behind, and this may be the potentially malignant one.

As a point in favor of removing ovaries it is generally noted by proponents that menopausal symptoms which may ensue can be adequately controlled with preparations now available. The ability to control symptoms, however, is a far cry from being able to restore a distorted endocrine balance and few physicians, I am sure, would claim any great proficiency in this regard. (Administration of insulin is a prime example of endocrine therapy which fails to prevent secondary disease processes.) If it were true that the endocrine system can be adequately controlled and balanced by hormone therapy, then it would not be necessary to set any specific age limit with regard to removing ovaries, not even the limit of 40 years.

Although menopausal symptoms occur in approximately 25 per cent of women after hysterectomy even when the ovaries are not removed,[9] it does not follow that the ovaries have ceased to function. All that can reasonably be said regarding the menopausal ovary is that it ceases to ovulate and to secrete progesterone rhythmically. Because the normal postmenopausal uterus does not bleed, it does not follow that the ovary is no longer active. The functions of the ovary are altered merely because body needs are altered and to these functions the uterus no longer responds.

If in fact the ovaries do have a function after the menopause, then removing them at age 40 or thereabouts would deprive the average woman, whose life expectancy is now 70 years, of useful organs for not less than a quarter of her existence. Certainly there is increasing evidence of continued ovarian activity beyond the menopause. The osteoporotic changes which occur in oophorectomized patients are noteworthy in this regard. And, according to Griffiths[4] the deleterious effects on the cardiovascular system are so important as to outweigh possible beneficial effects of castration except in exceptional circumstances.

We cannot, then, be dogmatic about this question at present. Individual assessment of each patient will probably yield optimum results. There is undoubtedly even an occasional elderly postmenopausal patient in whom the ovaries should be left and also now and then a patient under 40 who should have them removed. The patient who sincerely fears for loss of libido should not have oophorectomy—except in case of clear-cut necessity—regardless of age. In the patient with cancerphobia or a family history of cancer, oophorectomy should be done regardless of whether she is near the menopause.

Provided that the ovaries appear normal, that there is no history of carcinoma, and that the risk entailed has been clarified for the patient before operation, the ovaries can usually be conserved.

It is not always easy to decide whether the ovaries are normal. Naturally, the greater the surgeon's familiarity and experience with ovarian disease the less often will the issue be in doubt. Perhaps there is a place for routine biopsy by wedge resection of the ovaries in cases in which it is planned not to remove them. Some ovarian carcinomas have occurred within a year or two of the initial pelvic operation; this suggests that they may well have been present at the time of hysterectomy.

For physicians who feel that evidence concerning functional activity in postmenopausal ovaries is lack-

ing and that the risk of carcinoma warrants routine removal of ovaries, the age of the patient should not be of great moment since a 35-year-old woman free of ovarian disease has a greater chance of getting carcinoma of the ovary than an older woman with normal ovaries.[1] Statistically, it is just as reasonable to remove both breasts in all women at age 40, when these structures have no further physiological function but have a greater danger of carcinoma than all gynecological cancers combined.

The term *routine*, applied either to conservation or to removal of ovaries, has no place in our present policy on hysterectomy for benign disorders. The most favorable results will probably be achieved by pondering the individual merits of the procedure in each case.

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Allergy and the Atomic Age

BEN C. EISENBERG, M.D., Huntington Park

ALLERGISTS ARE AT LAST taking their rightful place alongside other medical specialists. They are seeing more and more of the serious problems in their field, whereas the milder cases are being handled quite adequately by generalists, internists and pediatricians.

Indeed, allergists doing investigative work in various medical centers of the world, including Russia, are contributing substantially to our body of scientific knowledge concerning basic immunology, the pharmacologic and physiologic aspects of many new drugs, fractionation of various antigens into their more reactive components, and the development of more effective means of combating diseases of hypersensitivity. In addition to their relentless attack directed toward unraveling the mysteries concerning the role of histamine in these reactions, many allergists are engaged in trying to find what part serotonin plays in allergic and inflammatory diseases. This research has been spurred on by three recent findings; namely, (1) serotonin (5-hydroxytryptophan) has been identified, along with histamine, in the lungs and sera of laboratory animals; (2) serotonin, like histamine, is capable of producing bronchospasm; (3) serotonin is released into the bloodstream, together with histamine, in experimental anaphylaxis.

Allergists not only are searching for more effective drugs to relieve persons with allergic disease but are attempting to perfect antigenic materials and methods for longer-lasting hyposensitization. Also, there is the never-ending search for those underlying structural, hormonal, and enzyme-system deficiencies responsible for mediating the allergic response. Some allergists are also studying the role of psychogenic factors in hypersensitivity and how best to deal with them.

Allergic reaction to foods is being intensively investigated. It has been found that, by testing with specific serum fractions through use of the Prausnitz-Küstner technique, sensitivity to foods may be uncovered, whereas reactions to the whole serum are often negative. This speaks for the presence of a "blocking" substance in unfractionated serum which prevents the detection of food reagins. These studies will be of great aid in the diagnosis and treatment of sensitivity to foods. Other investigators working with serum have succeeded in manufacturing "normal" antibodies against ragweed pollen and other antigenic substances. These antibodies can be used to prepare a vaccine for passive immunization and treatment of allergic diseases.

In spite of these advances, too many physicians still advise parents of allergic children to adopt a "do nothing" attitude regarding hay fever, asthma and eczema, claiming the children will "out-grow" these conditions. Much childhood and adult disability, such as facial deformities, malformed dental arches, hearing defects and chronic pulmonary emphysema can be prevented, or at least minimized, by helping the allergic youngster to resist repeated allergic and bacterial insult to the various tissues involved. This can be accomplished in at least 75 per cent of cases through a careful search for etiologic factors, including skin-testing and specific immunization where indicated.

Allergists must have well rounded medical knowledge. At one and the same time they must be good internists, capable immunologists and botanists, practical psychologists, endocrinologists, pharmacologists and discerning dermatologists. Specialists in allergic conditions must constantly be on the look-out for nonallergic diseases which often mimic the manifestations of allergic reaction. The dictum, all that wheezes is not asthma, simply means: Look for the exact cause—it may not be allergic. Likewise, all that vomits is not food sensitivity and all that sneezes or itches may not be due to a hypersensitivity reaction.

PSYCHOSOMATIC ALLERGY

At a recent session of the American Academy of Allergy, three speakers stated emphatically that they knew of no cases of eczema, asthma or other allergic disease benefited by psychotherapy. To me this is but an example of telescopic vision—seeing only what you want to see, believing only what you want to believe—for the facts prove otherwise. This is not to deny, however, that a far greater proportion of patients with allergic disease are improved by the specific etiologic and immunologic approach than by psychiatric treatment alone. The Atomic Age

Chairman's Address: Presented before the Section on Allergy at the 86th Annual Session of the California Medical Association, Los Angeles, April 28 to May 1, 1957.

From the University of Southern California School of Medicine, Los Angeles.

allergist must streamline his practice so as to include the dispensing of bits of "psychosomatic medicine" to patients who need it. This he can learn to do, provided he first develops an understanding, unhurried attitude that will encourage the patient to talk. Here, it is best to keep in mind one's limitations, and tactfully divert the stream of conversation away from areas beyond our capabilities. Where patients are not responding to the usual type of treatment, and it has been determined that a large portion of the problem stems from psychogenic factors, they should be referred to a competent psychiatrist, with continued symptomatic or other care carried out by the referring allergist.

There need be no difficulty in understanding the impact of emotions on disease processes, provided one recognizes that powerful, hidden forces may be generated by undue psychologic stress in connection with intense sibling rivalry or such repressed feelings as resentment, hostility, guilt, frustration and sex drives. Our newspapers speak daily of the havoc, crime and destruction such energy-potentials can wreak when they are not controlled. These same forces, when turned "inward," may facilitate or trigger such allergic responses as urticaria, migraine, vasomotor rhinitis or bronchospasm, as well as other reactions like hypertension, headache, cardiovascular irregularities and gastric distress. Hypnotists recently have, in fact, been able to reproduce urticaria and angioedema in certain subjects by recalling emotionally charged situations which were responsible for setting off these same reactions some time previously.

From this it follows that if a person with allergic disease learns to deal with his problems in a more mature, adult fashion, he may lighten his psychosomatic load, as it were, and have a better chance of obtaining a "cure." Here, psychotherapy by a specialist in this field may be of considerable help. By and large, however, it is usually not necessary to refer many cases for such treatment, most physicians being able to aid their patients adequately through proper guidance and counseling.

On the subject of psychosomatic allergy, I would like to outline some general impressions gained from observing many patients in clinic and private practice. Let me state at the outset that no concrete evidence has been brought forth to show that people with allergic sensitivity fit into a definite, predictable, emotional pattern. People are people, whether allergic or not, and are all subject to the same physical and psychological stresses and strains peculiar to the times or culture. There are exceptions of course, as, for example, persons who have incurred inordinate suffering at the hands of cruel or sadistic parents, foster parents, siblings or teachers, or those who have encountered unusually shocking experiences, serious accidents, profound illnesses or incest. Emotional trauma can leave permanent "scars" which may retard emotional maturation or warp the personality. This is especially true in the case of adverse psychological experiences occurring at an early age, or for that matter at any age, in certain predisposed or supersensitive persons.

Now, given just such a person, prone to easy anxiety and tension, who happens also to be constitutionally predisposed to allergic reaction, a single incident capable of producing emotional stress or a series of disappointing or frustrating experiences may "trigger," for the first time, asthma or other diseases of allergy. This can happen because of the powerful effects destructive emotions exert upon body chemistry, endocrines and other organs, and on the autonomic nervous system. Bronchospasm, edema, increased secretion of bronchial glands, and wheezing dyspnea mediated through such a mechanism are just as real as any produced by exposure of a susceptible individual to pollens, food, animal dander or injection of horse serum or drugs. Physicians requiring "proof" that psychogenic factors are capable of producing measurable evidence of physical bodily change need only collect the tears that flow from sorrow or joy, the stomach contents of the child who promptly vomits at the prospect of having to return to school and face a "mean, yelling" teacher or cruel playmate, or the sudden profuse discharge from the opposite end of the alimentary canal which happens to some persons when exposed to rather frightening experiences.

Of course, there are other important factors involved, each of which is capable of setting off the allergic response, given the proper set of circumstances—namely, hypersensitive tissues plus specific stimuli strong enough to evoke a reaction. Asthma, for example, may be incited by an attack of pneumonia or other respiratory infection, exposure to chemical fumes, such as chlorine or ammonia or motor exhaust, or following inhalation anesthesia or surgical operations on the nose and throat, after an injection of sera, vaccines or drugs, following severe physical exertion, or upon exposure to certain pollens, foods, animal danders, dust and many other substances ordinarily harmless to others.

Asthmatic attacks precipitated largely by emotional reactions have been seen by all of us—for example, following marriage, separation or divorce; following the loss of a close relative or friend; or in anticipation of an important event, including school proms, facing the boss, appearing in court, and the like. Actually, as far as the various etiologic components are concerned, an asthmatic person may require only a single physical or psychogenic factor, or a combination of several or all of them, to produce symptoms, and, furthermore, the "mixture"

may vary for different attacks. Thus, allergy may be likened to a pot of stew, in which the amounts of the various ingredients used—meat, potatoes, carrots, onions—may vary from time to time, but the end result is always stew.

It helps to clear some of the controversial cloud concerning the impact of emotions on disease processes if we but keep in mind the following points:

1. It is normal for each of us to feel and show evidence of emotional turmoil in especially trying circumstances. This in no way implies weakness or lack of fortitude.

2. The manner in which disturbance of this type is expressed differs from person to person, and any tissue, organ or system may become involved, be it from guilt, anger, resentment, fear, worry or frustration. One person may react with tachycardia, another with hypertension or gastrointestinal upset, speech disturbance, hyperventilation, sighing-dyspnea, cough, headache, blushing, urticaria, tremor, fainting or loss of memory.

3. Emotional conflict frequently is not apparent, and the patient may have no idea of its existence; indeed, where there are manifest signs and symptoms because of a disturbed psyche, a considerable portion of the conflict may remain submerged within the particular personality.

4. Signs and symptoms of personality disorders are labeled "pathological" when they become exaggerated over and above the normal response, or persist beyond a reasonable time.

5. Each person has his own particular breaking point—for some quite remote, for others near—beyond which he can no longer endure the adverse stimuli or inner conflict. When the limit is reached, he may "escape" into psychosomatic illness or actually become psychotic. Incidentally, the communists have made use of this principle in their "brainwashing" experiments on prisoners.

PHARMACOLOGIC PSYCHOTHERAPY

Tranquilizing drugs as used in dealing with patients with allergic disease may be helpful in allaying anxiety and tension states, and thus, secondarily, reduce the severity of allergic symptoms. We must be ever mindful, however, that these drugs may be toxic in some cases. Occasionally, combinations of two or more of them will produce a more favorable result. Some of the newer ataractic agents have been quite beneficial, as far as my own experience is concerned, in patients with chronic urticaria and angioedema. They are not too helpful in hay fever or asthma.

Atarax® (hydroxyzine hydrochloride), a comparatively nontoxic drug with very few side effects, is quite useful in treating allergic diseases involving the skin, especially when larger doses are administered than is usually recommended. Incidentally, six children with allergic disease who were given the drug for a two-week period stopped wetting the bed. I do not propose these drugs, however, as a cure for enuresis.

We now are being flooded by a rush of newer tranquilizers—a situation comparable to that seen during the past ten years with regard to the antihistamines. Most of the newer ones, however, are mild and less toxic, and are serving to replace largely the barbiturates. Among the latest additions to the field we may mention Pacatal® (10-(N-menthyl-3-piperidylmethyl) phenothiazine); Nostyn® (2-ethylcrotonylurea); Ultran® (2-p-chlorophenyl-3-methyl-2, 3-butanediol); Suavitil® (benactyzine hydrochloride); Quiactin® (oxanamide): Trilafon® (phentothiazine derivative). These modern dispensers of serenity are not expected to replace good, specific and immunologic therapy.

RADIOACTIVITY AND ALLERGY

Atomic labeling has provided a fascinating medical research tool with which to probe certain heretofore theoretic considerations concerning the site and mode of action and ultimate disposition of foods, drugs, and important chemical bodily constituents. Work is now under way to study that elusive and formidable substance considered to be involved rather intimately with allergic sensitivity—namely, histamine—by means of tagging this substance in the laboratory with atomic carbon (C^{14}). Atomic histamine is being administered to sensitized animals, and its ultimate disposition traced by means of a Geiger counter after the subject is given a shocking dose of antigen. This opens up a new field for interested scientists. Funds for this purpose are available upon proper application to the various allergy foundations and institutes that encourage research in the fields of allergy and immunology.

By means of the electron-microscope, so-called "cell-surgeons" are now able to observe directly the effects of allergic reactions on specific components of body cells. Manipulation of nucleoli and other cellular elements may also supply answers to questions concerning allergic sensitivity and heredity.

Another matter directly related to the atomic age concerns the possible allergic reactions of various degradation products resulting from exposure to atomic radiation and "fallout," and how these effects may be treated or prevented. A great deal of work has to be done in this area, over and above learning to deal more effectively with some of the major disasters of atomic explosions.

PREDICTIONS OF THINGS TO COME

In conclusion, let me say that our Atomic Age will yield the solution to many problems which have plagued allergists for many years. I would like to make the following predictions:

1. There will be discovered the specific metabolic, hormonal or enzyme deficiencies responsible for the failure of allergic persons to protect themselves from reactions of hypersensitivity; furthermore, once these substances are identified, true substitution therapy can be instituted, just as insulin is given for diabetes.

2. Effective vaccines containing anti-allergic antibodies will be manufactured for the passive immunization and treatment of patients with hypersensitivity to pollens, foods and other substances.

3. Highly accurate serologic tests will be perfected for the diagnosis of sensitivity response to foods, drugs and inhalants, utilizing specific serum fractions and antigen-antibody mixtures.

4. The influence of climatic factors, such as barometric pressure, humidity, altitude, particulate ionization, and air currents will be elucidated and methods to combat any adverse effects from these elements will be discovered.

5. The cause of those allied allergic conditions, the so-called collagen diseases, will be uncovered. Experiments already have shown the lesions of this group of conditions to contain antigen-antibody complexes. Once the cause, or causes, are found, modes of treatment will soon follow.

6. Better methods of prevention and treatment of industrial contact eczematoid dermatitis, which remains as the Number One cause of lost working man-hours, will be discovered.

7. The cortical and hypothalamic disturbances responsible for the triggering of "psychogenic" allergic disease will be intensely investigated and solved, with the production of an effective chemical agent to satisfactorily tranquilize or block such adverse neuronal activities.

8. Better methods will be developed for the prevention and treatment of pulmonary emphysema—a condition which is, apparently, on the increase and is "crippling" many young persons as well as the middle-aged. Also, more will be learned about the manner in which the broncho-alveolar junction becomes obstructed, and more effective drugs to combat this condition will be found.

9. Means will be found to render antibiotics, blood for transfusions, serums, and other injectables nonallergenic.

10. Simpler methods will be designed for accomplishing extracorporeal oxygenation of blood to circumvent the lungs in serious pulmonary cases (severe asthma, emphysema, pneumonia and operations on the lungs and heart). Also, it is not too far-fetched to predict that patients with emphysema will be enabled to resume normal activities by means of a bottle of liquid oxygen carried on their backs to provide necessary extrapulmonary gaseous exchange through capillary beds artifically constructed by surgeons; or small plastic oxygenators and pumps may be devised for strapping across the back and used for the same purpose.

2680 Saturn Avenue, Huntington Park.

Social Security Says:

"A WIFE OR WIDOW under 62 or the divorced wife of an insured person may receive payments only while she has in her care a child (under 18 years of age) who is entitled to monthly payments."

In other words: Many widows who married in their 20's and lost their husbands in their 40's, would not receive any survivors' benefits until they reached age 62 because their children would be 18 or older.

—From the Department of Public Relations, American Medical Association

CASE REPORTS

Mobile Cystic Teratoma

LOUIS J. BONANN, M.D., Los Angeles

DERMOID CYSTS OF THE OVARY are fairly common tumors which are readily identified in a roentgenogram when dental and osseous inclusions are present. Frequently, visualization of the tumor is enhanced by a thick fibrous capsule, demonstrable as a thin rim of increased density, delimiting the radiolucent lipoid or fluid content of the cyst. These roentgen features were fortuitously all very clearly recognizable in the following case.

Submitted February 10, 1958.

A 39-year-old Caucasian woman with ten living children and a history of three abortions had a 7 cm. dermoid cyst of the right ovary removed on January 20, 1956. She had felt something movable in the lower abdomen for several years which was inconstant in location. By pelvic examination and x-ray its mobility was confirmed. The x-ray demonstration of teeth, bone and fatty material inside a thick capsule made the preoperative diagnosis obvious (Figure 1). It was estimated at 10 cm. diameter, but the specimen measured only 7 cm.

University of California at Los Angeles School of Medicine, Los Angeles 24.

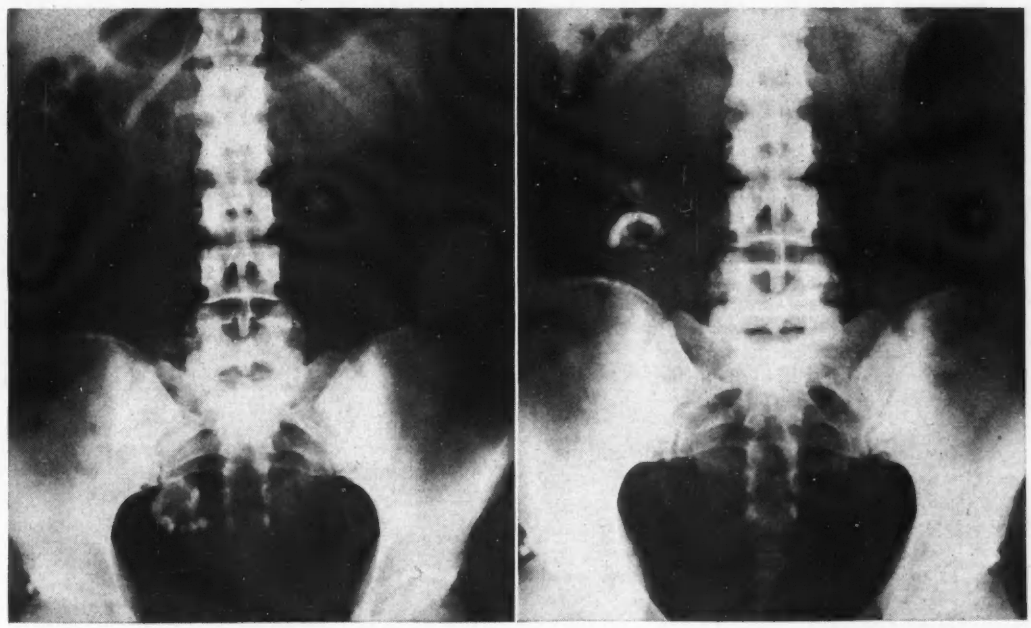

Figure 1.—*Left:* The preliminary roentgenogram disclosing dental and osseous elements on the right side of the pelvis within a rounded cystic area of radiolucency, completely encircled by a dense rim of fibrous capsule. *Right:* Anteroposterior roentgenogram of the abdomen, demonstrating the abdominal position of the mobile mass, now overlying the inferior pole of the right kidney.

Alveolar Soft Part Sarcoma of the Retroperitoneum

BLANCA SMITH, M.D.,
ANDREW J. McQUEENEY, M.D., and
D. R. DICKSON, M.D., Santa Barbara

ALVEOLAR SOFT PART SARCOMA, an unusual neoplasm of uncertain histogenesis,[1] has only rarely been reported in the retroperitoneal area. Smetana's comprehensive study[2] recorded only four such cases and the average age of the patients was 25 years. In the case here reported the patient was a 73-year-old woman and the first clinical symptoms were those of partial obstruction high in the intestine associated with severe secondary anemia.

REPORT OF A CASE

A 73-year-old white woman was admitted to Santa Barbara General Hospital on January 2, 1957, with complaint of progressive weakness, anemia, nausea and vomiting of six months' duration. There was a positive reaction for occult blood in the stool. Upper gastrointestinal roentgenograms showed medial displacement and partial obstruction of the second portion of the duodenum by a large mass in the right retroperitoneal area. Pronounced hydronephrosis on the right was demonstrated by an intravenous pyelogram, and retrograde pyelography showed decided distortion and displacement of the right upper ureter (Figure 1).

At laparotomy a large retroperitoneal tumor involving the right kidney and extending over the second and third portion of the duodenum was observed. It was considered nonresectable. The mass, approximately 20 cm. in diameter, appeared to be extrarenal and attached to the right psoas muscle with displacement of the right ureter and moderate secondary hydronephrosis of the right kidney. The external surface of the tumor appeared quite vascular and the cut surface of tissue obtained for biopsy appeared firm, gray and slimy. A palliative anterior gastroenterostomy was performed to by-pass the obstruction.

Postoperatively the patient received irradiation (tissue dose 3,000 r) to tumor mass in the right upper quadrant, with only minimal improvement. Weakness and anemia progressed, due to chronic loss of blood associated with ulcerative tumor extension in the duodenum. The patient died seven months after operation and approximately a year after onset of symptoms.

Pathologist's Report

At autopsy the retroperitoneal mass was observed to extend to the hepatic flexure of the colon, to the second and third portions of the duodenum and to the lower pole of the right kidney (Figure 2). Dissected from contiguous structures, the mass was a lobulated, ovoid tumor measuring 30 x 25 x 15 cm. Cut surfaces were pale ivory-white. The tumor filled the upper right retroperitoneum, producing a 15 x 6 cm. ulcerated tumor mass in the third portion of the duodenum. The posterior aspect of the tumor was attached to the right psoas muscle. Multiple distant metastastic lesions were present in the liver, pleura and lungs.

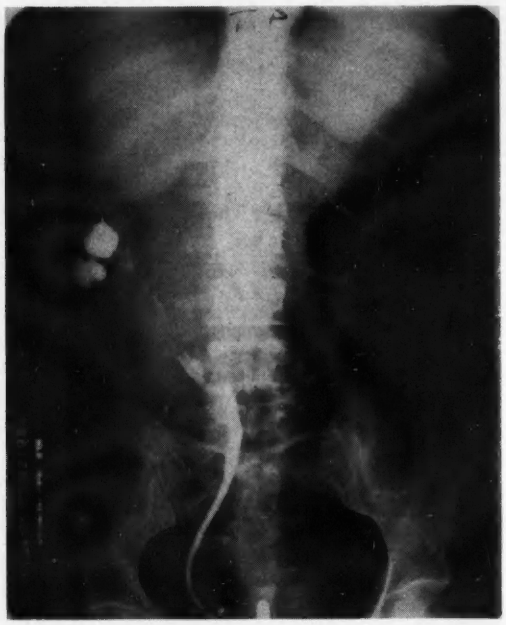

Figure 1.—Retrograde pyelogram showing distortion of right upper ureter due to retroperitoneal alveolar soft part sarcoma.

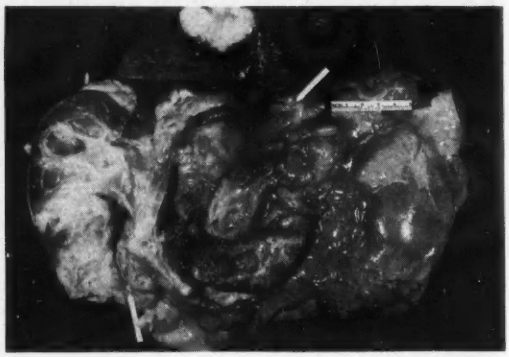

Figure 2.—Retroperitoneal alveolar soft part sarcoma, showing in situ relationship to right kidney and ulcerated duodenal tumor extension. (Probe in ampulla of Vater. Markers at pylorus and right ureter. Liver wedge with metastasis above.)

From the Departments of Surgery and Pathology, Santa Barbara General Hospital and Cottage Hospital, Santa Barbara.

Submitted February 27, 1958.

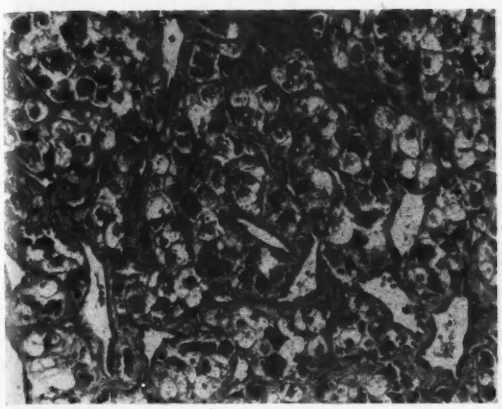

Figure 3.—Primary retroperitoneal alveolar soft part sarcoma (×100) showing characteristic alveolar cell grouping and prominent sinusoidal vascular pattern.

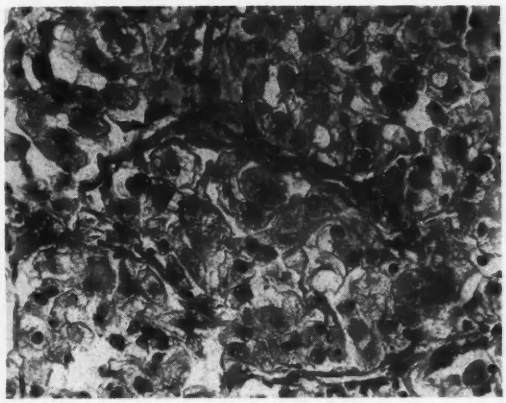

Figure 4.—Gomori trichrome (×400). Pulmonary metastasis of alveolar soft part sarcoma, showing preservation of original growth pattern, with scattered mitoses, one of which is visible centrally.

Microscopically, the tumor consisted of irregular, rounded groups of large cells surrounded by capillary vascular spaces which often appeared compressed, but occasionally were dilated in sinusoidal fashion, producing an organoid or "endocrine" type of arrangement (Figure 3).

Individual tumor cells generally appeared polyhedral or spheroidal in outline. They ranged from 15 to 70 micra in diameter and had an abundant eosinophilic granular or homogeneous ground-glass cytoplasm which often appeared vacuolated but contained scanty sudanophilic material and no demonstrable chromaffin granules. Cell nuclei were rounded to ovoid with vesicular or reticulated chromatin, usually showing a single, slightly acidophilic nucleolus. Mitoses were rare in the original surgical material, but averaged one to three per 10 high power microscopic fields in the postirradiation autopsy specimen (Figure 4).

SUMMARY

A case of alveolar soft part sarcoma of the retroperitoneum in an elderly woman is reported. Autopsy findings included ulcerative invasion of the duodenum and distant visceral metastasis following irradiation therapy.

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ACKNOWLEDGMENT

We are indebted to Fred W. Stewart, M.D., Memorial Hospital, New York, and W. K. Bullock, M.D., of the Tumor Tissue Registry, Cancer Commission, C.M.A., for confirmation of the diagnosis in this case.

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Brucellosis—A Case Study

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THE CHRONIC FORM of brucellosis may present many subjective symptoms which are difficult to distinguish from those of psychoneurosis—symptoms such as excessive fatigability, myalgia, low-grade fever, depression, insomnia, headache, anorexia and loss of weight. In the acute form of the disease symptoms are more objective. The onset of acute brucellosis is variable, but usually is initiated by fever of the rising "septic" type with morning remissions. Associated with the fever are a slow pulse, neutropenia, diarrhea, headache, depression, muscular aching, fatigue and shifting joint pain. When fever is of the undulant type, febrile episodes persist for ten to twelve days and are followed by periods when the patient is afebrile and asymptomatic. In most cases there are no such undulations and the patient remains ill for two weeks to ten months. In the differential diagnosis of brucellosis, consideration should be given to typhoid fever, Q fever, miliary tuberculosis, chronic recurring infectious mononucleosis, pulmonary or systemic coccidioidomycosis, rheumatoid arthritis, and Boeck's sarcoid.

The clinical diagnosis of brucellosis, therefore, must be substantiated by laboratory diagnosis. Of the many laboratory procedures available, the only absolutely diagnostic criterion is a positive blood culture. If routine blood cultural methods are used, the chance of identifying and isolating the organism

From the Services of Dr. A. G. Bower, Chief Physician, Communicable Disease Unit of the Los Angeles County General Hospital.

Submitted January 20, 1958.

is practically nil. By use of special culture media—trypticase soy broth and agar cultures—under anaerobic conditions the organism can be identified in a higher proportion of cases whether in the afebrile chronic state or in the acute stage.

The diagnosis of brucellosis by means of a high agglutination titer is generally, but not absolutely, reliable. Huddelson reported cases of negative results of agglutination tests in bacteriologically proven cases of infection with *Brucella abortus*. Also persons vaccinated against cholera may have high titers for brucellosis. An agglutination titer of 1:80 or higher, with either a rising or falling titer during the course of observation, is usually regarded as indicative of the disease.

The complement fixation and opsonocytophagic tests has given unreliable results and as a consequence has been discarded by most clinicians. The brucellergin skin test is still in use in diagnosis by some clinicians, but most have discarded it as not diagnostic. It may cause a local slough at the site of injection, and it may induce antibody formation which later will interfere with evaluation of agglutination titers. Negative results of the brucellergin skin test have been reported in many cases in which bacteremia was demonstrated, and positive skin reactions have been reported in persons having no clinical manifestation of disease.

REPORT OF A CASE

Four weeks before admittance to hospital, a 64-year-old unemployed Mexican farm laborer had chills and fever while vacationing in Juarez, Mexico. The chills and fever occurred on alternate days for a total of five days and were associated with cramping pains in the legs. Upon subsidence of fever, diarrhea developed, the patient passing seven to fifteen yellowish watery stools a day. This persisted until admittance to hospital. Four days before admittance, fever recurred and the patient then for the first time sought medical attention. He was referred to the Communicable Disease Unit of the Los Angeles County General Hospital because of suspicion of typhoid fever. The patient had received no antibiotics or sulfonamides during the previous month. He had lived in Juarez, Mexico, until 1956, but said he had had no similar episode.

He was observed to be depressed, lethargic and confused. The temperature was 100.8°F., the pulse rate 104. No rash, joint involvement or splenomegaly was noted. Leukocytes numbered 3,500 per cu. mm., with 49 per cent neutrophils. The serum agglutination titer for brucella was 1:10,240 on one occasion and 1:5,120 on another. *Brucella abortus* was cultured on trypticase soy broth and agar in three separate blood cultures.

The patient was started on a ten-day course of 1 per cent sulfanilamide in sodium lactate Ringer solution by hypodermoclysis and 1 gram of streptomycin every 12 hours. The blood level of sulfanilamide was to be maintained at 15 mg. per 100 cc. or higher. The original dose was calculated at 0.12 gm. per pound of body weight to be given in three equal doses at eight-hour intervals over a period of 24 hours. This amount was gradually decreased, but the blood level of the drug remained at 30 to 40 mg. per 100 cc.

During therapy, blueness of the lips and skin was noted. Methemoglobin determinations were done and values as high as 0.17 mg. per 100 cc. were obtained. The sulfanilamide dosage was diminished but not discontinued. Ascorbic acid, 500 mg. three times a day was given and the bluish color diminuted. The urinary pH was maintained at 7.5 to prevent sulfa-crystal formation in the urine. Serum electrolytes remained normal throughout therapy. On the eighth day of therapy the patient became afebrile, but subjective depression did not subside until a week after cessation of treatment. He was discharged on the 24th day of hospitalization, two weeks after fever and other symptoms had disappeared.

SUMMARY

A patient admitted to hospital with suspicion of typhoid fever, had high titration for brucellosis, and *Brucella abortus* grew on a culture of blood. The patient was treated with sulfanilamide and streptomycin and a cure was effected.

Wadsworth General Hospital, Sawtelle and Wilshire Boulevard, Los Angeles 25.

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California MEDICINE

For information on preparation of manuscript, see advertising page 2

EDITORIAL

C.M.A. Changes Structure

DECISIONS of the 1958 session of the House of Delegates resulted in several changes in the structure of the California Medical Association and in a number of operational adjustments in the workings of the organization.

Principal adjustment in the basic structure of the C.M.A. came in the adoption of amendments to the Constitution which alter the allocation of members of the Council.

Under the Constitution as it was written prior to last April 30, the Council consisted of eleven District Councilors, each chosen by the elected Delegates of his own geographical district, and six Councilors-at-Large who were elected by the House of Delegates. In addition, the President, President-Elect, Speaker and Vice-Speaker of the House of Delegates served on the Council with full powers, and the Editor and Secretary served ex-officio without the right to vote.

With Councilor Districts set on the basis of geographical lines, the former setup permitted one district with as few as 360 members to name one member of the Council, while other districts with as much as ten times that membership were likewise limited to one Councilor.

The constitutional amendments voted on April 30 provided for a proportional representation on the Council, based on one member of the Council to be named by his own District delegates for each 1,000 active members in the District. A minimum of one Councilor for each district was written into the amendments, so that all areas of California will have a Council representative, regardless of the limited membership in any district. Under this setup the two Councilor Districts which formerly covered Los Angeles County have been combined into one district. The other nine districts remain the same. However, the Los Angeles County district is now entitled to six Councilors, each of the remaining districts to one Councilor; and the former Councilors-at-Large have been eliminated.

The President, President-Elect, Speaker and Vice-Speaker of the House of Delegates retain their former positions as members of the Council and the Secretary and Editor continue as ex-officio members. This makes a Council of 19 voting and two non-voting members, two less than the former membership.

In the new setup there are counter-balances to compensate for the addition of four Councilors in Los Angeles County: Formerly, two Councilors-at-Large came from that county, and the Speaker and Vice-Speaker of the House of Delegates likewise were Los Angelans. By voting out the Councilors-at-Large and by electing a Vice-Speaker from another county, the House of Delegates actually raised the Los Angeles County representation on the Council by only one member. At the same time, the House provided that at no time could the number of District Councilors from any one district exceed 40 per cent of the total Council membership.

Besides these changes through amendments to the Constitution, the House voted a number of internal changes in the Association. For example, by a change in the By-Laws the office of Secretary-Treasurer was renamed to eliminate the "treasurer" part of the title. All duties of the "treasurer" have for many years been handled administratively, so that part of the old title had become meaningless.

Under the revised By-Laws, the Secretary is continued in his principal activity as chairman of the Committee on Scientific Work, which makes up the Annual Session program.

The former Auditing Committee was renamed the Finance Committee in another amendment which also spelled out more clearly the manner in which annual budgets shall be prepared and presented for vote.

Duties of several officers were realigned in other amendments to the By-Laws which were designed to bring C.M.A. activities up to date in the light of current activities.

Disciplinary procedures were also altered in two other By-Law amendments which eliminated the previous limitation of one year on the time a member could be suspended. The House followed the reasoning of the proponents of this measure that some latitude should be permitted in disciplining a member between the extremes of a short one-year suspension and an outright revocation of membership.

The House of Delegates also acted to change the dues structure for physicians starting in medical practice and for those engaged in postgraduate study or disabled by protracted illness. These changes will eliminate a great deal of paperwork and make the work of county medical society secretaries easier.

In another amendment, the House voted to eliminate the Executive Committee as an official body and to replace it with a smaller group of top officials empowered to act in case of emergency but limited in their actions by the need of Council approval. Now that it has become the policy of the Council to hold meetings monthly, the functions of the Executive Committee as an administrative body have declined to a point where this change will contribute to a smooth operation of the Association.

Many of the amendments adopted at the 1958 session stemmed from the structural study of the Association made late in 1957 by Robert Heller and Associates, Cleveland business engineers. The Heller studies pointed to several areas where C.M.A. operations could well be streamlined or modernized. In addition, several By-Law changes were prepared by the Council and by the special committee which last year studied the Constitution of the Association.

Adoption of three amendments to the Constitution and ten to the By-Laws points up the fact that any organization must take time out periodically to bring its official documents up to date. As was demonstrated by the 1958 House of Delegates, the ruling articles of an association can become cluttered with outdated requirements which may be retained for sentimental or other invalid reasons, and hence need reviewing from time to time. As so often happens in such circumstances, a whole series of amendments are easier for the legislative body to swallow than would be a single proposed change which might carry the aura of bias or special privilege.

It is obvious that the conduct of the California Medical Association will be strengthened under the changes voted this year. At the same time, the House of Delegates has expressed its complete willingness to consider and vote on changes designed to make for better or more efficient operations.

Editorial Comment . . .

The Job and the Man

COMING AT A CRITICAL TIME in the progress of the Stanford University School of Medicine, Dr. Robert H. Alway's recent acceptance of permanent appointment to the deanship of that institution can be doubly celebrated.

1. The job, more than ever demanding, now that large scale removal of Stanford's Medical School facilities from San Francisco to a great new teaching center on the Stanford campus is going forward, is one for a man who is at once physician and educator and administrator and work-horse. The job has found the man. As acting dean, Dr. Alway had been doing the job for some time, and recently at last was persuaded by the university's president, Wallace Sterling, to reconsider his original refusal to take the position permanently.

2. In his first public statement after accepting the appointment, Dr. Alway not only showed a full understanding of all the implications of the tasks before him but also his words conveyed a feeling of the beginning of strong bonds such as those that, now and again, ideally bind a man to a job and a job to a man.

The purpose of consolidating the Medical School on the University campus, Dr. Alway said, is "to increase the breadth and effectiveness of medical teaching and education.

"It will be contrary to these aims if the full-time faculty is not free to devote its principal energies to teaching and research, undiluted by the demands of private medical practice.

"The medical faculty will care for patients, of course, being obligated to use its knowledge and skill for the benefit of humanity. Its teaching is all the more effective when it does so.

"Until the Medical School's financial resources allow adequate full-time salaries, some faculty members in the clinical departments will engage in lim-

ited private practice as at present. Most of the patients seen by faculty will be on referral from other physicians, and their number must be limited to the requirements of teaching and research. The medical faculty will instruct students and carry on research, not engage in the practice of medicine to support the school."

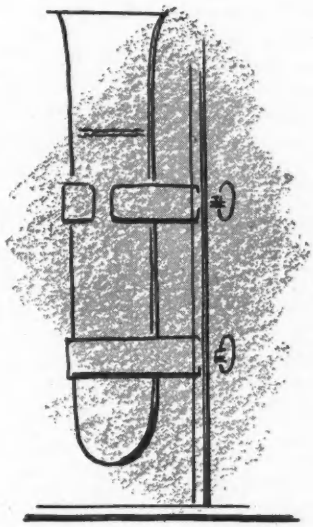
As to the future of Medical School facilities in San Francisco, Dean Alway discussed the proposed modernization and continued operation of San Francisco Stanford Hospital as a private hospital. "The hospital would have an intern and residency training program, and might also have a limited research program with the necessary library facilities. These would be administered by the Medical School.

"The San Francisco Stanford Hospital and any training and research program would have to be entirely self-supporting. Financing construction and operation of the new Medical School on the campus precludes continued University support of the San Francisco operations. This will preclude, as well, continuation of an outpatient or hospital clinic service there."

On the much discussed questions of the movement of medical faculty members to Palo Alto next year and the availability of voluntary faculty, Dr. Alway spoke with diplomatic forthrightness:

"We believe that full-time faculty whose activities have been and interest are concentrated in medical education and research will make the move. We also believe that the voluntary faculty in San Francisco will continue to teach at Stanford in Palo Alto, just as their fellow practitioners from the Peninsula and other Bay Area communities faithfully have come for so many years to Stanford in San Francisco."

Besides this realistic attitude, Dr. Alway has these recommendations: His ability to do the job is already proven, and now in accepting the appointment he has shown that his desire to see it done well has outweighed his hope that someone else might be found to do it. Job and man seem to have come to a happy union.



California MEDICAL ASSOCIATION

NOTICES & REPORTS

Transactions of the House of Delegates

Los Angeles, April 27 to 30, 1958

The 1958 House of Delegates of the California Medical Association transacted a record business. It acted upon one proposed amendment to the Constitution which included four parts, on 17 proposed amendments to the By-Laws and on 72 resolutions.

This volume represents more than double the business coming before the House in 1957.

To handle the extra load, Doctor James C. Doyle, Speaker, named two additional reference committees, so that three committees handled new business and reported to the House. All resolutions were classified into the broad fields of public assistance, medical economics and general business, so that related items could be studied and resolved together. As a further means of assuring coverage of all items and eliminating overlapping, the members of the three reference committees on new business met before making their reports to the House of Delegates and reviewed the entire list of resolutions so that they could be properly assigned.

Of great help in the handling of such a volume of business was the cooperation of the county medical societies and their delegations in transmitting resolutions to the C.M.A. office in advance of the meeting. This enabled the office to prepare and place in the hands of the Delegates as they were seated about 75 per cent of the total business to come before them. While the House did not act favorably on a proposed By-Law amendment to require the advance presentation of all new business, it was obvious that the Delegates favored advance notice on the business they must consider and would cooperate in seeing that the members of the House are notified in advance of the work to come before them.

The following report of the transactions is an abridgement. A complete transcript of all sessions of the 1958 House of Delegates is on file in the Association office in San Francisco and available for the inspection of all members.

* * *

At the first session of the House of Delegates of the California Medical Association, Sunday morning April 27, 1958, Speaker James C. Doyle named the following members to Reference Committees and their appointment was accepted by the House.

REFERENCE COMMITTEES

The Committee on Credentials: Finis G. Cooper, Huntington Park, chairman; Joseph G. Middleton, San Luis Obispo; George H. Houck, Palo Alto.

Reference Committee 1. Stanley R. Parkinson, Marysville, chairman; Howard E. Clark, Monterey; Fred E. Bradford, Los Angeles.

Reference Committee 2. Francis N. Hatch, Modesto, chairman; Donald M. Campbell, San Francisco; James J. Morrow, North Hollywood.

Reference Committee 3. Frederic Ewens, Man-

hattan Beach, chairman; John G. Morrison, San Leandro; Joseph W. Telford, San Diego.

Reference Committee 3A. Robb Smith, Orange Cove, chairman; Robert C. Combs, San Francisco; William F. Quinn, Los Angeles.

Reference Committee 3B. Burt Davis, Palo Alto, chairman; Robert L. Stern, Beverly Hills; Norman C. Fox, San Bruno.

Reference Committee 4. J. B. Price, Santa Ana, chairman; Roderick A. Ogden, Bakersfield; Robert B. Haining, Glendale.

Reference Committee on C.P.S. Business: Lewellyn Wilson, Anaheim, chairman; John F. Mayo, Lodi; Cedric C. Johnson, Santa Rosa.

The Constitutional Study Committee (to report Resolution 2 of the 1957 House of Delegates): Sam J. McClendon, San Diego, chairman; Robb Smith, Orange Cove; C. J. Attwood, Oakland; Matthew Hosmer, San Francisco; Carl Hadley, San Bernardino; Marden Alsberge, Glendale; James Moore, Ventura; Fred Olson, Fortuna; James Yant, Sacramento; Jay J. Crane, Los Angeles; Leslie Magoon, San Jose.

The Reorganization Committee (Resolution 24 introduced in the 1957 House of Delegates): Frederic Ewens, Manhattan Beach, chairman; Dwight Murray, Napa; John Cline, San Francisco; Lewis Cline, San Francisco; Dan Kilroy, Sacramento; John Rumsey, San Diego; James Feldmayer, Exeter.

The Adoptions Committee (on Resolution 41 introduced at the 1957 House of Delegates): Frances Holmes, Los Angeles, chairman; Russell Mapes, Beverly Hills; Joseph Telford, San Diego; Lee Fulton, Redding; Henry Tieche, Fresno; Jack Rovane, Sacramento; Agnes Plate, San Francisco.

* * *

Mrs. Leonard D. Offield, President, Woman's Auxiliary to the California Medical Association, addressed the House of Delegates on the activities of that organization and urged greater use of the Auxiliary's forces and talents for medical public relations.

ADDRESS OF THE PRESIDENT

FRANK A. MACDONALD, *President*

Mr. Speaker, members of the House of Delegates, and guests:

As physicians, the greater portion of our daily thinking is concerned with the welfare of our patients, with scientific advances in medicine and with the multitude of duties associated with modern medical practice. As citizens, our minds are occupied with the problems of inflation, rising living costs, excessive taxes and spiraling wages. Consideration of these factors must of necessity occupy the greater portion of our daily thinking and seldom allow us an opportunity to consider carefully the serious problems which confront medicine.

So let's take a short recess from our daily activities and analyze some of these controversial problems. Scientifically, medicine has made dramatic progress for which the American public is wholeheartedly grateful. Our major difficulties lie in the fields of medical economics, legislation and in the political arena.

I. *Organizational and Administrative Problems*

For many years the C.M.A. has been growing faster than any other state medical association in this country and now boasts of over 16,000 members. With this rapid growth, mounting problems of an organizational and administrative nature have developed. The A.M.A., when confronted with similar problems last year, employed business experts to analyze its entire structure and subsequently obtained a blueprint for present and future improvement.

The Council in September of 1957, after careful investigation, instituted a similar survey in California. The same group of experts, Robert Heller & Associates of Cleveland, were employed and their report was completed in December of 1957. The Council has made many changes of an administrative nature in accordance with the California Heller Report. This report was also made available to the Constitution Study Committee appointed in conformity with Resolution 2 passed by this House in April of 1957. This special committee will report to the House of Delegates at this session and will make specific recommendations for organizational changes in the C.M.A.

In my opinion the California Heller Report has been of great assistance in high-lighting opportunities to improve the administrative and organizational structure of our Association. After careful consideration of this report by the House, the major problems in these fields should be settled satisfactorily for the present and a blueprint will be available as a guide for the future. I believe this entire situation was handled in an intelligent, efficient and business-like manner which should serve as a pattern for solving similar problems.

In conformity with these same business principles, a building was purchased in San Francisco in November of 1957 to permit future expansion of our rapidly growing central office. With this purchase, space requirements should prove satisfactory for many years.

II. *Communication*

With the rapid growth of an organization as large as the C.M.A. it is obvious that our lines of communication must be under constant scrutiny with a view toward making the transmission of information to individual physicians as perfect as is humanly possible. Recently a communications failure occurred during negotiations on the Public Assistance Program when information from the C.M.A. central office, after being forwarded to county medical societies, in some instances stopped at top county levels and was not transmitted to individual physicians.

Subsequently these methods of communications were improved but additional techniques remain to be utilized. For example, the basic function of county medical societies is changing rapidly since both specialty organizations and general practitioners now arrange scientific sessions at which subjects of special interest to their particular group are discussed. Hospital staff meetings likewise emphasize scientific problems as they relate specifically to hospitals. Consequently, county society meetings are frequently poorly attended, since subjects of widespread interest are limited. It would appear logical for county societies to gradually vary their programs so that more subjects of a medico-politico-economic nature are discussed. Debating these issues should generate ideas, stimulate interest, increase attendance and disseminate information in a manner which should be of important benefit to medicine. In addition, more data should be included in society bulletins of a medico-economic, medico-legal and political nature. Finally, the organizational sections of state and national journals should be followed by physicians with the same interest as the scientific portions.

The Heller Report suggested additional avenues for improving communications by arranging local meetings of C.M.A. alternates and delegates with District Councilors between the regular meetings of the House of Delegates. Conferences between these delegates and the District Councilor should serve as a "two-way street" by which local societies can become better informed of the C.M.A. activities and the Council in turn can keep more closely in touch with "grass root" opinions.

All of these suggestions should prove helpful in remedying the C.M.A. communications problem and additional methods may be devised by further observation and analysis of deficiencies.

III. *Medical Fees*

Bargaining with the state and federal governments and with various insurance carriers over medical fees is becoming increasingly important to medicine and, as would be expected, has aroused widespread criticism and controversy throughout the profession. Many physicians believe they are allowed no part in these deliberations in spite of the fact that their elected representatives do the actual bargaining. However, there may be some justification for this feeling among physicians that they have no voice at the bargaining table and, although there is no simple answer to this criticism, a remedy must be found.

The most recent attempt in California to arrive at a median fee for physicians occurred three years ago. Since that time many inflationary changes in the national economy have occurred and a new and more realistic survey of median fees in California is necessary immediately. Hereafter this survey should be conducted on a yearly basis in order to keep this data up-to-date. Unit values should be adjusted to the second edition of the Relative Value Study in accordance with the findings of these surveys which should represent the average fees charged by physicians in California.

In addition, at least one county society meeting each year should be devoted solely to a discussion of medico-economic problems at which the County Fee Schedule Committee should present the findings of the local yearly survey and should encourage discussion of these fees by individual physicians. The results of these deliberations should then be made available to the C.M.A. Medical Services Commission and should be given careful consideration in arriving at a median fee for the C.M.A.

The Council of the C.M.A. should set no medical fees in future except in an emergency, and then the fees should be of a temporary nature and should apply only until such time as they can be fully discussed in reference committees by the elected delegates from each society. You may be assured that the Council will gladly relinquish this task. Delegates should be given full opportunity to analyze these schedules and to officially vote their approval or disapproval at the House of Delegates meeting.

From a technical standpoint this procedure has been followed in general in the past, but opportunities for individual participation in fee determinations must now be stressed. Each physician should be encouraged to discuss fees individually and freely at his county society meeting. His elected representatives should present these views before the proper reference committee and later should make the final official decision. With this procedure no physician could justly feel that he had no voice in the establishment of his fees. This method may seem cumbersome and costly but no amount of time, effort or expense should be spared in solving this extremely important problem in intra-professional relations.

IV. *Professional Liability*

This problem is among the most important that faces medicine today. If some solution is not found shortly, scientific medical progress will be jeopardized. Many approaches to the professional liability problem have been attempted, some of which have proved valuable and others have failed. Psychological studies, which investigated attitudes in the causation of suits, were extremely interesting and for a time appeared to offer definite answers to this problem. However, the action program based on these psychological studies did not prove as valuable as anticipated and this approach does not now appear to be a major factor in the solution of the practical aspects of professional liability. Jury studies being conducted by the Medical Review and Advisory Board may clarify certain aspects of this complicated problem.

Claims prevention programs in hospitals through active tissue and record committees, through efficient supervision of hospital professional work and through education of the physician in avoiding the pitfalls in medical practice should assist in reducing the number of professional liability claims. These are the basic tools over which the profession has control. More positive use must be made of these corrective powers in order to lower professional liability actions and to raise the standards of medical care to the public. More recently the limited use of pre-trial examinations has proved beneficial in eliminating unreasonable and unjustifiable suits. Impartial panels of medical experts are now being selected in each county throughout the state to assure that competent medical testimony will be available to attorneys at all times.

Medicine must realize that the public is not concerned with the professional liability situation and that this problem must be settled by the profession itself. However, if every physician would become medico-legal minded and would learn to give careful consideration to the professional liability features of a case, along with its scientific aspects, the major portion of this problem would be solved. Postgraduate courses now being given in these subjects should prove helpful in attaining this aim.

V. *The Third Party Problem*

One of the most important and most highly controversial subjects in medicine today is the "third party" problem. This is a general term applied to any group which intervenes between a patient and his physician in rendering medical care. The "third party" usually consists of an insurance company, a prepaid group-practice organization, a union health and welfare plan or a governmental program. This subject has become so acute that five states introduced separate resolutions into the A.M.A. House of Delegates last June in an attempt to resolve differences of opinion involving medical care under union health and welfare funds derived from "fringe benefits."

Let me give you a few figures to help you decide for yourselves the importance of "third party" intervention in medical affairs. The annual report of the Health Insurance Council states that almost three and two-thirds billions of dollars were handled in health claims by third parties during 1956. In other words, doctors have been separated from their patients financially and hospitals have been forced to deal with intervening groups to the tune of that amount. "Third party" contracts handle ten million dollars in medical and hospital care daily in this country. In California it can be reasonably estimated that one million dollars per day is paid by third parties. It can be stated positively that these amounts will increase, not decrease.

Who controls these funds, how they are handled and how they affect the quality and quantity of medical care, are questions of vital concern to the medical profession. Blue Cross, Blue Shield, commercial carriers and certain state and governmental programs are considered less controversial than other plans which involve prepaid, closed-panel systems and which attempt to control medical practice. Medicine can logically expect increasing competition from prepaid group-practice organizations and union health and welfare plans. In an attempt to resolve differences of opinion between medicine, on the one hand, and labor and industry on the other, over "third party" relationships, the A.M.A. House of Delegates in June of 1957 adopted three basic principles covering the treatment of patients under the U.M.W.A.F. They intend to develop similar guides in the future for other closed-panel groups. These principles are:

1. Free choice of physician and hospital.
2. Fee-for-service.
3. Liaison from below upward.

These fundamental principles represent medicine's answer to competition from closed-panel systems and union health and welfare plans in general and will form the basis for future negotiations in national controversies involving these groups. Every physician should subscribe wholeheartedly to these principles which aim to maintain high standards in the practice of medicine.

Labor consultants made certain requests in California in April of 1957 which can be summarized briefly as follows: (1) Complete medical care, preferably on a service principle. (2) Certainty of coverage. (3) Fee schedules for competitive bidding

among insurance companies. (4) Low administrative costs (2 to 3 per cent). (5) Premiums which they consider reasonable.

The C.M.A. Council on July 13, 1957, answered the above requests and stated that they had no authority to dictate to members, that service plans such as CPS could be recommended only where inadequate income was involved, that relative value fee studies could be used, that public service committees should be consulted when disputes occurred and that discussions between labor and medicine should be continued.

Meanwhile, there are signs that California labor leaders are becoming more familiar with problems involving the medical care of their members and that California medical leaders are learning the value of continuing discussion and deliberation at state level. For these reasons both groups are approaching more closely although there still remains a considerable gap between them.

Both medicine and labor aspire to the identical time-honored goal, namely, "the best medical care at a price which every patient can afford to pay." However, medicine has continuously stressed quality in medical care, while some labor leaders have favored salaried "captive physicians" in the employ of prepaid closed-panel groups, chiefly because of their apparent low cost. The acceptance of major medical, co-insurance and deductible features in insurance contracts would rapidly narrow the gap of misunderstanding between labor and medicine. In fact, this disagreement and the refusal of labor leaders to use public service committees represent our major stumbling blocks at present.

Suits are on file in Colorado and Ohio to determine whether physicians or labor leaders will control medical society membership and the outcome of these court deliberations will help to decide medical standards for the future.

However, many enlightened consultants for labor health and welfare plans have accepted basic medical principles and, with continued discussion and experimentation, it is not unreasonable to hope that labor leaders themselves will gradually follow the advice of these consultants and make medical decisions on the basis of what is best for their members. In my opinion, continued negotiations with those consultants who control labor's health and welfare funds offer greater hope for a satisfactory settlement of this problem than prolonged discussion with less informed labor leaders. The C.M.A. Council is willing and desirous of cooperating along these lines in order to solve this extremely important and complex problem.

VI. *Government-Financed Medical Care*

Socialism may be defined briefly as the public collective ownership of land and capital and the public collective control over individuals, industries and professions. Veterans with service-connected disability, a large proportion of the dependents of military personnel and all public assistance and indigent cases have been socialized for medical care under this definition for many years. They look toward public collective management, *i.e.*, government, for this care; and government in making these groups, among many others, wards of the state has accepted this responsibility insofar as their medical needs are concerned. Three government-financed medical care plans are in effect (or are being considered) in California, namely, the Home Town care of Veterans Program, "Medicare" and the Public Assistance Plan. These specific groups formerly were treated medically by salaried physicians in Veterans' hospitals, by military personnel, by interns, residents and other physicians employed by the city, county or other political subdivisions and by volunteer physicians.

More recently government has made certain changes in the handling of the medical treatment of these dependents. Under federal law, private practitioners of medicine can now participate in the care of groups which formerly were treated by salaried physicians. Certain specific restrictions have been imposed by government on this medical care, including the type and amount of coverage, fees for professional services and the total money available for diagnosis and treatment. The government calls the tune, pays the bills and demands the usual excessive red tape, paperwork and regimentation.

Nevertheless, there are certain features in this new relationship with government which should be given careful consideration by medicine. For example, free choice of physician and fee-for-service are permitted, physicians individually and collectively can accept or reject these programs, medicine is allowed to select its own administrative agent in most cases and can bargain collectively for fees. These government-financed medical care plans for limited segments of the population have increased the total pool of individuals available for private practice and have transferred patients from public clinics and hospitals to the offices of private practitioners.

Although 19 million dollars previously had been allocated yearly in California for this program, the addition of 29 million dollars specifically earmarked for categorical medical care undoubtedly represents an extension of socialization in a program which in 1956 cost the state government approximately 375 million dollars. Furthermore, the lack of adequate funds to render complete medical care to these recipients necessitates excessive regimentation by the State Welfare Department.

For these and other reasons, many physicians consider that these programs represent a serious encroachment of socialization in medicine. Is this a valid conclusion? If so, then we discover several amazing paradoxes. The Veterans Administration looks with extreme disfavor on the Home Town Care of Veterans Program for obvious reasons and has managed through devious methods to eliminate this plan in all but eight states and Hawaii. Medicine, on the other hand, favors this program and the A.M.A. is attempting to extend its scope to additional states. Thus we have the strange paradox, if this veteran's care plan is truly socialistic, of seeing the government vigorously oppose socialism and the medical profession with equal vigor favor socialistic encroachment. Obviously this isn't reasonable. Opposition to "Medicare" by private practitioners will restore the care of military dependents to salaried physicians in service under government control. Lack of medical support for the Public Assistance Program will return these recipients to county clinics under salaried physicians or the State Welfare Department will be forced to employ physicians on salary in geriatric or pediatric clinics. For these reasons medicine can, if it so desires, exercise partial control over these programs.

However, there are many aspects of these plans with which many physicians disagree and others of which they heartily disapprove. In addition they dislike the excessive paperwork, the obviously inadequate fees, the governmental regimentation and the red tape and many of the annoying and frustrating characteristics of these plans. Nevertheless, I sincerely believe, from discussing these programs with many county medical societies and many individual physicians, that the chief opposition to these plans lies in the basic distrust of government by medical men and the sincere fear that medicine will eventually be socialized through these programs. Unquestionably there is justification for this concern.

However, let's consider these plans collectively as vehicles for the gradual extension of socialism in medicine by government. There can be no doubt but that government is gaining actuarial and statistical data from these plans which will prove extremely helpful to politicians in advancing future socialistic medical programs. Nevertheless, I sincerely doubt that medicine need fear socialization from these arrangements for definite, practical, economic and political reasons with which all physicians should be thoroughly familiar.

In order to understand this situation clearly it is necessary to take a quick look at the Social Security Act. This law became effective in 1936 and is divided into two portions: Title I, Old Age Security (O.A.S.) and Title II, Old Age and Survivors Insurance (O.A.S.I.). In my opinion medicines' main battle must be directed against O.A.S.I. rather than against O.A.S. for specific reasons which require further discussion.

First, let's consider O.A.S. Politicians realize that the American public does not want regimented medical care and that to bring it about they must resort to piecemeal, indirect and devious legislation. Taxpayers as a whole are forced to support charity welfare plans under O.A.S., and increases in the public assistance funds must come from the taxpayer's pocket. Increasing taxation is a technique which is obviously unpopular with the American taxpayer especially at the present time, consequently politicians prefer to avoid this method if possible.

On the other hand, under O.A.S.I. the employee pays a portion of the cost, the employer a similar amount; and, unknown to the American taxpayer, he underwrites the entire plan through hidden taxes. This so-called "insurance" scheme covers virtually every employee and employer in this country, together with the dependents of employees and excludes only physicians and certain governmental workers. Minor amendments to Title II of the Social Security Act (O.A.S.I.) by Congress at each session could gradually result in the socialization of medicine without the actual knowledge of or undue concern or criticism from the major portion of the American public. These amendments are readily added to law since the familiar argument is used that the individual is paying the cost himself and therefore is definitely entitled to all these benefits "by right."

Anyone who questions the above opinion can find a ready answer in the token resistance, consisting of one letter, offered by the A.M.A. against the Long Amendment to HR 7225 (the Public Assistance program under O.A.S.), in comparison with the extremely vigorous fight staged by the A.M.A. against the George Amendment to HR 7225 (cash disability at age 50 under O.A.S.I.) and in the active opposition now being organized by medicine against the Forand Bill (also under O.A.S.I.).

Every physician must obtain a clear-cut picture of these programs at present and must understand their significance to the practice of medicine in future. Basically these three federally-financed medical care plans are identical in principle and must be considered as one unit.

This House of Delegates finds itself on the horns of a dilemma and must decide either to oppose in principle the three federally-financed plans presently in effect in this state and draw the line at that level or to accept the basic philosophy of these programs and battle against further governmental encroachment and intervention by actively opposing future amendments to O.A.S.I. If this House of Dele-

gates should decide to oppose only one of these plans, for example, the Public Assistance Program, then it should, in order to be factual and consistent, make a careful distinction between opposition "in principle" and opposition due to "unnecessary regimentation, excessive paperwork, inadequate fees or political expediency." Furthermore, physicians must realize that they can hardly favor free choice of physicians and fee-for-service in principle for the general public and oppose free choice and fee-for-service for indigents.

This problem should not be decided on the basis of our present annoyances, frustrations and prejudices but must be considered from an unemotional, realistic, practical, long-range viewpoint in which the future relationship of this plan to medicine's battle against socialism is carefully weighed and critically evaluated.

VII. *Encroaching Socialism*

If medicine eventually becomes socialized, it will occur through increasing amendments to the Social Security Act, Title II, O.A.S.I. for reasons already outlined. Consequently, it is extremely important that medicine scrutinize any suggested amendments to this legislation.

The first and most important change in this Act, from a medical viewpoint, occurred with the passage of the George Amendment to HR 7225 in 1956 by two votes over the vigorous opposition of the medical profession. This law permits the payment of cash for total and permanent disability at age 60 rather than at age 65. In other words, physical disability has been singled out as a reason for the payment of social security allotments at the earlier date. At first glance this may not seem very important but on more careful analysis it will be found to represent the greatest legislative defeat suffered by medicine in our time. Adequate definition of the word "disability" is difficult and its interpretation can be easily changed by future legislative amendments. In addition, the word "permanent" can be readily changed to "partial or temporary" and the government can then demand proof of this disability by physical examination. At first, these examinations would be paid for by the patient and eventually by the government. From this brief outline the serious menace of the legislation becomes obvious.

Another attempt will be made by socializers this year to encroach still further upon the practice of medicine. The Forand Bill, HR 9497, introduced on July 24, 1957, is a proposed amendment to Title II, O.A.S.I. which would, among other changes, initiate hospital, nursing care and surgical payments for persons eligible for retirement or survivorship benefits under O.A.S.I.

This bill has the active endorsement of the CIO and AFL unions and the surgical portion of the proposal appears to be based on the experience of the UMWAF in five different states. This proposed legislation will be discussed in detail by the A.M.A. and C.M.A. legislative committees, so it will not be considered further except to outline an improvement in plans for opposing this type of legislation in California.

The Council, in agreement with recommendations of the Heller Report, has advised District Councilors and county society delegates and alternates to cooperate more closely and actively with the C.M.A. Legislative Committee and with county legislative committees in publicizing medicine's opposition to the proposed legislation and in bringing medicine's opinion to lay groups such as civic, church and educational associations, insurance, industrial and financial organizations and laborers, veterans and other taxpayers.

According to the reliable *Wall Street Journal*, "Over 100 lawmakers of both parties have dropped benefit-boosting bills into Congressional hoppers since last January." In our zeal to oppose the Forand Bill we must not lose sight of other amendments to O.A.S.I. in the medical field, which, if enacted into law, might permit government to advance further along the road toward socialization.

In Conclusion

The recent controversy over the Public Assistance Program has aroused physicians in this state to the vital importance of national and state legislation to medicine. At no time during the past thirty years has the profession in California been so stimulated politically except during the 1945 campaign when it opposed the then Governor Warren in his unsuccessful effort to force medicine into socialization. While the reasons for this recent controversy were unfortunate, there remains a silver lining to the cloud in the sudden awareness and active opposition on the part of the profession to further socialistic proposals by government.

In discussions with county medical societies during the past two years, I have endeavored to stress those principles which must be emphasized by physicians individually if medicine hopes to continue as a reasonably independent profession. These responsibilities underlie many of our major problems and bear repetition.

1. It is becoming more evident daily in the present political struggle for power between labor, industry and government that medicine is being "caught in the middle" and can survive, as we know it, only if we are a highly organized group. The medical profession, according to the politician, is so small numerically that we are unable to exercise

important power at the ballot box. Therefore, physicians must demonstrate to the public both by precept and by education the benefits derived from freedom in the practice of medicine. We must decide what is best for those we serve and then follow a specific course irrespective of all obstacles. We must use the influence of this group to determine the social and economic conditions under which our services are rendered.

2. Since medicine is rapidly being forced into the world of commerce, we must accept the bargaining tools of trade and learn to use them intelligently. We must cooperate fully within the profession in order to bargain successfully and to assist in establishing those principles for which we stand. What is good for the individual physician is not necessarily good for medicine; whereas what is good for medicine is always good for the individual physician. It is essential that we assume these responsibilities in order to render the finest medical care to the public in the present rapidly changing social and economic climate.

3. Medicine, if it is to protect the public, must continue to insist on its two great fundamental principles, namely, fee-for-service and free choice of physician and hospital. These are the basic principles which have made American medicine great.

While we as physicians are confronted with grave problems and vast responsibilities, we are also presented with broad opportunities and a great challenge. The advancement of medicine as a science will depend to a great extent upon how well we meet this challenge. (Applause.)

SPEAKER DOYLE: Thank you, Dr. MacDonald.

PRESENTATION OF FIFTY-YEAR AWARDS

Awards of pins commemorating 50 years of membership in the California Medical Association were made to the following physicians:

Dr. William P. Byron, Lemoore, Kings County.

Dr. Edith E. Johnson, Palo Alto, Santa Clara County.

Dr. A. W. Connor, San Jose, Santa Clara County.

STUDENT A.M.A. REPRESENTATIVES

The following representatives from California medical schools to the Student American Medical Association were introduced:

From the University of California: Henry Ralston, Jr., and Thomas Moyers.

From Stanford University School of Medicine: Wilmer Allen and Charles Hewl.

From the College of Medical Evangelists: Eugene Shakespeare and Fritz Westerhout.

From the University of California at Los Angeles: Carl Younger, national vice-president, Student American Medical Association; Harold Allen and E. Conway Stratford, Jr.

From the University of Southern California: Joseph Krofcheck and Richard Goode.

SUPPLEMENTAL REPORTS

The Speaker called for supplemental reports, beyond those made by various officers and committee chairmen in the Pre-Convention Bulletin, and the following reports were given:

REPORT OF LEGAL COUNSEL

MR. HOWARD HASSARD

Mr. Speaker and members of the House of Delegates:

This supplemental report is caused by the time lapse between preparation of our written report in January and several major issues of medical policy that have come to the fore since the first of the year. This report will be in the nature of a summation of the legal position of the profession in relation to economic as distinguished from professional problems in medicine.

In the immediate past these specific events have occurred:

1. A federal court has recently held that an Arkansas physician denied membership in his local county medical society could not invoke the Sherman Anti-Trust Act. There was no question of contract practice nor was a third party payment plan involved. The physician was a solo practitioner. The court held that the practice of medicine is neither trade nor commerce, and that if the denial of membership did interfere with the physician's practice such interference would not cast any burden on interstate commerce.

The case establishes that the practice of medicine *per se* is a profession, not a business, and hence is not within the ambit of the anti-trust laws.

2. At the same time two physicians in Colorado have commenced a $75,000 damage suit against a county medical society, claiming a restraint unlawful under the anti-trust laws, in that they were denied membership by the society on the ground that they participated in the United Mine Workers health plan. As you know, the United Mine Workers have a large fund for the payment of hospital costs and physicians' services incurred by miners and their families. At first, the Mine Workers fund permitted free choice of hospital and free choice of physician. In recent years, however, the fund has imposed re-

strictions on freedom of choice, and in various areas of the United States the medical profession has reacted aggressively as could be expected, in opposition to limiting patients' prerogatives. One weapon claimed to have been utilized to combat the Mine Workers fund has been society membership. *Life* magazine's issue of April 21, 1958, portrays the dispute and states: "Medical societies have begun denying membership and hospital privileges to U.M.W. doctors . . . doctors caught in between took their troubles to court."

While California lacks coal deposits and therefore is not directly concerned in the Mine Workers dispute, nevertheless all physicians throughout the United States are indirectly concerned, in that once again the issue is clearly raised as to what steps the profession may lawfully take to combat an economic force which medicine considers inimical to its economic interests.

3. In recent months our office has been questioned several times by physicians and medical groups as to whether organized medicine could improve its legal latitude in combatting economic encroachments, whether by government or private interests, through utilization of a labor union form of organization.

Frequently in recent months we have been asked to express an opinion as to the lawfulness of organized "non-participation" in a governmental program of medical care.

Due to these events I believe it timely, and I hope helpful in your deliberations, for me once again to review the status of medicine (regardless of how organized) under the anti-trust laws, and to define to the extent possible the boundaries of the playing field.

Basically, the anti-trust laws were enacted to protect free competition in all business activities. The motive was to protect the right of all Americans to improve their economic status without destruction by more powerfully entrenched competitive forces.

When medicine was practiced on a fee-for-service basis, and only the doctor and patient were involved in both the physician's services and the patient's obligation to pay therefor, there could be no destruction of competition arising from such relationship, and hence the physician and the anti-trust laws were strangers, and neither was concerned with the other.

However, when patients commenced to protect their economic interests by arranging for payment of the physician's fee through group action, an entirely different situation arose. The group arrangements for payment are an economic mechanism, not a professional matter; and such group arrangements, no matter what form they utilize, constitute businesses and as such are protected by the anti-trust laws against outside destruction. In this situation the practice of medicine *per se* is not the subject matter; the subject matter is the business of financing the costs of medical care.

Medicine first ran afoul of this fact in the early '40's when the American Medical Association and the Medical Society of the District of Columbia were proceeded against criminally by the United States Department of Justice. Parenthetically, I should emphasize that violation of the anti-trust laws is a crime as well as a wrong that can be the subject of a very expensive damage suit.

The A.M.A. case reached the United States Supreme Court. That court upheld a criminal conviction of the A.M.A. and the local medical society, because the court found that the A.M.A. by coercive tactics had attempted to destroy the business of a closed panel organization known as Group Health, Inc. The coercive methods used included ostracizing any physician who worked for Group Health, denying him county society membership, and closing hospital staff privileges to him. The Supreme Court said that it needn't decide whether the practice of medicine is subject to the anti-trust laws, because that was not the question involved. It said that the real question was whether the business of paying the costs of medical care was within the protection of the anti-trust laws; and the court's answer was Yes.

The court held—and this is now the law of the land—that a medical society to attain its economic objective may use reasoned persuasion but may not resort to coercion, either of its own members or others. The court said:

"If the District Society, acting only to protect its organization, regulate fair dealing amongst its members, and maintain and advance the standards of medical practice, adopted reasonable rules and measures to those ends, not calculated to restrain Group Health, there would be no guilt . . ."

May I emphasize, medicine may promote its economic view by reasoned persuasion, but if it resorts to coercion it may and has run counter to the nation's anti-trust laws.

The next medical anti-trust case to reach the United States Supreme Court was the other way 'round. It was an action brought by the United States Department of Justice against the Oregon State Medical Society to enjoin the Oregon Society from, among other things, continuing to sponsor Oregon Physicians' Service, the Blue Shield plan in Oregon, on terms different than were accorded commercial organizations. Here the Supreme Court said that medicine, far from interfering with economic competition, was itself engaging in such competition

and was doing so on a lawful and fair basis. The decision was in favor of the Oregon Society.

I should add that the evidence in the case established that the physicians had not engaged in coercive tactics against the contract practice associations operating in that state.

There have been several other anti-trust cases involving medicine, in Washington, Minnesota, Oklahoma and San Diego, but they merely serve to confirm the pattern established by the United States Supreme Court.

In the field of economics and in the business of financing the costs of medical care as the courts have ruled, medicine may reason and persuade but it may not resort to force, coercion, retaliation or duress.

This restriction on medicine's economic power has caused physicians to wonder from time to time whether medicine wouldn't be more effective if it were organized as a labor union. This query presupposes that labor unions are above the law. They are not. It is true that by statute and by court decision labor has won the legal right to engage in a strike against an employer for the purpose of improving wages and working conditions. True, any strike is a restraint on the business of the employer. But the right of labor to strike is not unlimited; labor's right is expressly confined to the employer-employee relationship and to the dual purposes of wages and working conditions. Whenever the strike weapon is used beyond these limited purposes, the courts have interfered and will interfere. In addition, when unions use their economic power outside of the authorized strike area to injure someone's business, they are liable under the anti-trust laws, and there are many cases in which unions have been found guilty of anti-trust violations.

The very pattern of the practice of medicine makes it impossible for medicine to fit into the collective bargaining strike zone of labor unions. By whom are physicians employed? If there is an employer, it is each and every patient. Against whom, then, could physicians strike? In all other areas the anti-trust laws would apply to medicine, whether organized as a medical society or a union.

Finally, I come to the question of governmental programs. With respect to the government, organized labor's right to strike is denied. Under the Taft-Hartley law it is unlawful for any government employee to participate in a strike against the government. Under the federal and California labor relations laws, public employees, whether federal, state or local, do not have any right to engage in collective bargaining. These restrictions probably had their origin in the disastrous railroad strikes that occurred immediately after World War I when the railroads were being operated by the United States governmental agencies. In any event, the right to strike against the government is, in a word, nonexistent.

This does not mean that in programs of medical care financed by the government individual physicians are forced to participate. Each physician may accept or not accept a government-financed patient as his own judgment and conscience dictates. But organized coercion to force physicians to act collectively for the purpose of destroying a lawfully established government medical program would, in my judgment, run afoul of the same public policy that denies to the employees of the government the right to strike against the government.

I think it is necessary to conclude that the union form of organization is unlikely to give medicine any wider legal latitude either in relation to private businesses or the government, than is now possessed by the profession. I suspect that in the field of economics medicine will, of necessity, have to live within the rule laid down by the United States Supreme Court, which I may oversimplify as follows: Persuasion—Yes; Coercion, No. (Applause.)

SUPPLEMENTAL REPORT OF THE COUNCIL

DR. DONALD D. LUM, *Chairman*

Mr. Speaker and members of the House of Delegates:

The *Annual Reports Bulletin* which you have before you contains the Report of the Council as prepared several months ago.

At this time the Council will report on additional items which have come before the Council since the original report was prepared or have been decided subsequently.

First is the matter of resolutions referred to the Council by the 1957 House of Delegates or indirectly so referred by the language of the resolution.

Three resolutions were referred directly to the Council by this House in 1957.

One of these, Resolution 8, Claude Calloway of San Francisco, author, urged that medically indigent patients who are beneficiaries of public welfare benefits be treated through private physicians and clinics associated with teaching institutions. The Council followed the intent of this resolution in its dealings with the State Department of Public Welfare under the new Public Welfare Assistance Law, legislation for which was passed shortly after the 1957 meeting of this House.

Resolution 38, Leon P. Fox of Santa Clara County, author, asked that nurse educators be impressed with the need of more bedside teaching. At the time this resolution was before the members of this House, legislation was progressing in Sacra-

mento which has subsequently established a shortened nurse training course for recognition for registration. This legislation is for an experimental period of five years, during which time there will be an opportunity to evaluate the efficacy of nurse training under a two-year program. The Council will follow the progress of this program and consider steps to be taken at any time in regard to it.

Resolution 40, J. P. Sampson of Los Angeles County, author, urged opposition to legislation which would lower the standards for foreign medical school graduates seeking to practice here. The Council has consistently opposed this type of legislation and has worked to maintain our high standards. A new organization, the National Council for Foreign Medical Graduates, has now been established by the American Medical Association, American Hospital Association and other recognized groups to provide a screening procedure for foreign medical school graduates. Time will be needed to determine the effectiveness of this screening procedure but it is obvious that it will give at least some indication of the qualifications of those who seek to come here from other countries and will eliminate those who are patently unfit to practice in California.

In addition to these resolutions sent directly to the Council, six other resolutions last year called for Council consideration.

Resolution 9, Donald M. Campbell of San Francisco, author, asked the development of a department and personnel in the Association to represent the C.M.A. before various bodies. The Council deferred decision on this matter until the Heller Report became available. Since that time the Association's staff has been augmented and a start made in the direction of the intent of this resolution.

Resolution 14, Burt L. Davis of Santa Clara County, author, asked consideration of legislation which would provide for the establishment of knowledge of the actual cost of injuries in court cases involving personal injuries. In view of the late date at which this resolution was adopted and the nearness of adjournment of the 1957 state legislative session, such legislation must necessarily be deferred until 1959. However, it is worthy of note that an interim committee of the State Assembly is currently inquiring into this field and has been furnished a copy of Doctor Davis' resolution for its consideration.

Resolution 10, Henry Gibbons of San Francisco, author, proposed that a staff be developed to implement the Committee on the Unlawful Practice of Medicine. Doctor Gibbons has appeared before the Council in support of this resolution and the subject remains open on the Council's calendar. However, it should be pointed out that there is a difference of opinion on this subject, based upon a consideration of the propriety of the Association's entering into activities which are currently the province of public law enforcement agencies.

Resolution 15, Grant Ellis of Alameda County, author, urged the establishment of a statewide hospital accreditation board for the promotion of advanced standards for our hospitals. Inasmuch as the Joint Commission for the Accreditation of Hospitals covers this field under standards which are applicable and are understood throughout the country, the Council did not feel that the establishment of a state board, to which the national organization would be considered in a secondary light, would represent much of value and might react unfavorably by debasing the national organization. Consequently, the Council has not taken any positive action on this proposal.

Resolution 25, Alf T. Haeren of San Mateo County, author, asked that opinion polls of the membership of the Association be taken on important matters. The Council is aware of the intent of this resolution and is prepared to utilize methods and facilities at its command when questions arise on such topics

Resolution 35, Clyde L. Boice of Santa Clara County, author, suggested that Council meetings be planned in various cities in the state so that local society officers might attend such meetings and better inform themselves on the deliberations of the Council. Two weeks ago the Council held its meeting in Sacramento, with officers of the county society present, and, while no schedule of such meetings can be announced at this time, the Council is aware of the benefits of such planning and will keep them in mind.

The Council also wishes to acquaint the members of this House of Delegates with the problem now faced in nominating candidates for election to the Board of Trustees of California Physicians' Service.

Under the C.P.S. By-Laws the Council is asked to nominate each year one candidate for each pending vacancy on the Board of Trustees and to place the names of these nominees in the hands of the members of this House 30 days in advance of the meeting. In addition, the Council is called upon to name three of its own members each year to serve a one-year term on this Board.

In view of the Constitutional Amendment which has been lying on the table for one year, and which will be voted upon later today, the composition of the Council during the coming year cannot be forecast at this time. It is most important that the three Trustees of C.P.S. named from the Council membership be carefully selected so that a direct liaison

between the C.P.S. Board of Trustees and the C.M.A. Council can be maintained. At the same time, it is equally important that the other trustees, who will serve terms of three years each, be most carefully selected for their ability to serve C.P.S. well.

Because of the uncertainty as to the composition of next year's Council, and because of the importance of these nominations, the Council has not yet placed any nominations in your hands. When this House of Delegates has taken action on the Constitutional Amendment now lying on the table, the Council will be in a position to make such nominations and will do so.

The Council wishes to nominate for election to honorary membership by this House of Delegates one of our members who has devoted herself to the cause of medicine far beyond the normal call of duty.

Doctor Edith Mary Meyers of Alameda County graduated from University of California Medical School in 1926 and entered the practice of pediatrics, a specialty in which she subsequently became a certified specialist. In 1948 she retired from the active practice of private medicine but continued to devote herself to good medical works.

For the past ten years she has maintained an active membership in her local, state and national medical associations, has paid full dues and has given freely of her time, her talents and her funds in the interest of good medical care. She has served throughout this period as head of the out-patient department of Children's Hospital of the East Bay, without recompense. She has served on the Council of the Alameda-Contra Costa Medical Association, has been chairman of that society's Child Welfare Committee, Credentials Committee and Advisory Board to Visiting Nurses, and a member of the Tuberculosis Committee.

Doctor Meyers has also, at her own expense, represented the society at the C.M.A. School Health Conferences and served on the Planning Committee for the School Health Conference held in Berkeley.

Honorary membership in the California Medical Association is seldom granted, and, on such occasions as it has, the recipient has always been a physician whose good deeds were outstanding. It is the sincere belief of the Council that Doctor Edith Mary Meyers qualifies for this honor and the Council respectfully nominates her for election by this House of Delegates to honorary membership.

The House of Delegates last year asked the Board of Trustees of California Physicians' Service and the Council to investigate the feasibility of providing members of California Physicians' Service with plastic identification cards. The Board of Trustees of C.P.S. did investigate this possibility and found the idea to be impractical because of an estimated cost of several hundred thousand dollars to provide the members with plastic identification cards and furnish physicians with equipment to handle such cards.

Finally, the Council has reviewed the various programs under which governmental units purchase medical services from physicians for various segments of the population. I am sure you have all been aware that during the past year the Council has been faced with numerous serious and very perplexing problems.

I would like, Mr. Speaker, to ask your permission to invite President-Elect West to discuss the thinking of the Council upon many of these matters.

SUPPLEMENTAL REPORT OF THE PRESIDENT-ELECT

DR. FRANCIS E. WEST

Mr. Speaker, members of the House of Delegates:

I have been instructed by the Council to address you concerning the problems of fees, service and indemnity type plans of prepaid medical insurance and the attitude of the Council toward these major issues. The tenor of this statement is the unanimous opinion of the Council; quite reasonably these are details which are open to much debate.

It is strongly felt that this House in the next few days must face certain issues and delineate policies to be followed. However, the Council, which sits in session at monthly intervals between the annual meetings of the House, would be derelict in its duty if the members failed to outline what has been the product of their experience during the past few years.

Perhaps if it were possible, we would be happy to renounce all third party fee arrangements and start over again, but we cannot. The Workmen's Compensation Act, Crippled Children's Program, Veterans Home Care Program, our own C.P.S., and "Medicare" make this as impracticable and untenable as it is unreasonable. Many of these programs operate with onerous rules and regulations, with fixed and frequently inadequate fees. And, in some instances, the question may arise whether there is even free choice of physician.

Since we cannot abrogate our position in relation to many of these plans, it becomes our responsibility to adjust our thinking and attempt to adopt general over-all policies which will be acceptable to the majority.

To aid in this undertaking, let us review some of our past actions.

In 1952 we had a C.P.S. Study Committee that faced these problems. After one and one-half years of diligent effort and some $50,000 expenditure, the committee made a definite recommendation to this

House. In 1954 Doctor Magoon read the report to you and it was received with standing acclamation. This committee recommended the Usual Fee Plan and indemnification as the basic type of medical insurance for general use.

A short time later, however, because of other problems, this House approved, as a temporary expedient, an increase in the income ceiling of C.P.S. to $6,000, which meant a service type insurance policy with a fixed (and, incidentally, low) fee schedule. Now these two actions seem to be fundamentally opposite fiscal policies and lead to confusion of both the public and the doctor.

The Council has not known for sure which of these actions—the Usual Fee Plan or the fixed fee service insurance plan—were to be followed. Meanwhile, there seemed to be instances where both plans were needed.

When the problem of "Medicare" came before the Council there were several men who on the basis of principle voted against accepting the program as offered, in that it was to be a service type plan with a fixed fee schedule administered by a government agency. However, "Medicare" was accepted and, in general, is being rather happily carried out by most doctors. Some of the complications, however, are now becoming apparent and we are beginning to harvest the results.

For instance, the Public Assistance Program is another government plan similar to "Medicare" but covering a different group of individuals, a somewhat different group of doctors, and with a slightly modified fee schedule; yet there are a tremendous amount of complaints.

These programs are part of one of the policies that medicine has been at least partially endorsing since 1939—that is, prepayment of premiums for the purchase of medical services, operated on a service type program with fixed fees.

At the present, we find ourselves at the end of a blind street. It seems we have now reached the point in logic—the conclusion—which inevitably follows once you accept a premise.

Every avenue we have followed for the past twenty or twenty-five years is converging to the point of putting a price on our service.

The report from the Public Relations Committee; the report from the Legislative Committee; the Medical Services Commission, and now the report from your Council—all arrive at this same conclusion: Medicine must face this problem of fees and the type of medical care insurance which we are all willing to recommend, to understand and abide by.

This problem of fees is intrinsic, because it is the product which becomes inevitable when one recommends prepaid medical care insurance. It makes little difference who handles the policy. When we endorse the principle of insurance as one method for the public to obtain their medical services, the people will then demand that we place a price on the service.

The only way to avoid discussing this problem of fees is to repudiate all previous actions and start anew. We on the Council do not feel that this can be done or that this House would want us to do so.

The Council feels we must face these issues squarely. We are aware the case is difficult and at times seems impossible, because it appears that by giving in we will ultimately be controlled. While the task is formidable, we must come to grips with the problem and set a realistic and reasonable policy that all of medicine, and the public, can understand and live by.

This House will have to face the fundamental issue of what we are going to do about fees.

The Council at this time would like to outline some thoughts for the benefit of your discussions.

We feel that probably there is no single complete answer to all aspects concerning fees. Confusion is great because we are speaking about many various government plans, the Workmen's Compensation Act and the general public, which includes both low income and adequate income groups.

For a logical approach, we would like to separate the problem into two component parts, one involving the adequate and other the inadequate income group. First, what can be done for substandard income groups, which would include: (1) Certain individuals who just do not have enough money to purchase adequate medical care; (2) certain employed groups with low incomes; and (3) certain governmental charges who are underprivileged.

It seems necessary to distinguish the group of governmental charges, as it would appear we are all going to be considered government charges under the Forand and similar bills. But there are certain governmental charges who are underprivileged. For years both medicine and the government have recognized these people and have given them medical care which probably is somewhat socialized. We prided ourselves on giving services not at reduced fees, but frequently for nothing. We have been proud to do this and we are sure most of us, if let alone, would continue to do so.

Then finally, there is a fourth category in the reduced income group—those who more recently have been taken care of to a great extent by the popular approach of the public agencies. These are people who are in need, with specific types of disease processes which are debilitating both physically and economically. This group could properly fall into

the realm of substandard income, or the medically indigent.

These four groups are entitled to consideration by medicine; whether it is the fellow who is just not making enough money, or whether it is the charitable attempt of the public agency. Or, in some instances, the benevolent taxpayer wishes those less fortunate be offered additional medical care and is willing to have certain amounts of his tax dollars appropriated for this care.

We feel in these instances that the intent on the part of either the agency, the taxpayer, or the individual, is good, and perhaps medicine should be willing to talk to these people about giving them a service type contract which would have a fixed fee schedule, and in certain instances, where the need is properly evaluated, and meets the proper definition of medical indigency or substandard income, to reduce our rate of pay.

The degree of reduction should depend on the degree of need of the individual. In some instances perhaps, this should be negotiated, or would, of necessity, be negotiated.

This type of coverage with fixed fee is service type insurance. Ideally, it should be offered through our agency, C.P.S., because it is the only vehicle in which the doctor has agreed to a fixed fee schedule. Any deviation from this vehicle becomes dangerous because we then tend to do what has probably been a fault in our approach during the past few years; we commit the doctors of the state to a fee by moral suasion. The Council recognizes this fact and wishes to be relieved of this problem.

In the case of the Public Assistance Program, approximately $30,000,000 annually is being spent in California on medical services. No matter what fee schedule is set, some doctors would have to accept it as a means of maintaining their practices. Therefore, we should have plans which are previously decided to be acceptable to all physicians of the group who are obliged to serve these plans. C.P.S. would be the logical organization to implement these programs.

We do not believe there are many physicians who have any real serious misgivings about how medicine will cooperate in taking care of people who are truly indigent or really have inadequate incomes.

The benevolent attitude of medicine toward the indigent, toward the unfortunate, has not changed. There is no cause for concern about charity care, since all of us have been donating this, as have our predecessors from time immemorial.

What is of concern is the fear of dictation in the matter, and the manner of the delivery of this charity or near-charity care.

In other words, if we are to give our services on this basis, we believe we have every right to say how our services shall be given.

The second group on which medicine must take a definite stand in regard to fee arrangements is the adequate or standard income group. This is by far the largest segment of our medical practice, and it is this group which presents the greatest problem.

The Council feels the earlier report of the C.P.S. Study Committee is still good and that there is probably no reason to have it changed or to develop a new Study Committee.

There is no question that when medicine suggests and offers prepaid health insurance as the way for individuals to take care of their health needs, it becomes a responsibility of medicine to offer some degree of certainty of coverage per premium dollar. It just isn't fair to do otherwise. The people concerned in this adequate income group are: (1) People insured by private insurance companies; (2) people under certain C.P.S. contracts; (3) people under labor contracts, and (4) government employees and others who are not indigent and who do have adequate incomes. This latter group is very important, as we feel there will be a large number of people in the future under government contracts who will not justify our setting either a fixed fee or reduced fee schedule.

In this group, medicine must meet its problems; but it must not be caught in the tangle of working down from its usual or modal fee. We cannot therefore properly offer a statewide service type contract with a fixed fee schedule.

We are aware that, in spite of this fact, certain doctors in certain areas will do so; some closed panel groups will be formed, and some doctors will sign up with certain insurance companies to serve some plans. That is an individual problem. But medicine, as an organization, should maintain its dignity and preserve that which is best for the patient and the profession and refuse to sanction such programs.

For this normal income group we would favor the annual establishment by this House of Delegates of what is found, by thorough and continuing investigation, to be the usual or modal fee for medicine throughout the state, fully realizing and adequately stating, that this is a median or modal fee and that there will be higher and lower fees charged in certain areas by certain doctors and under certain circumstances. This, then, means that the C.M.A., as a group, cannot endorse a statewide service type insurance program for adequate income groups.

For these groups, plans could be written against what are the modal fees throughout the state, with the insured recognizing that the final charges rep-

resent differences in particular areas and differences in particular doctors. In cases of fee disputes, however, as suggested in 1954, the usual or modal fee would be accepted as standard unless the physician had discussed his charges with the patient in advance.

This suggested statewide policy would not restrict any county society from accepting any contract which it might wish to arrange locally, such as a service type plan with a ceiling income limit. It is proper, important and right to maintain local autonomy.

At present this is being done in Stockton and in Long Beach. And I understand it is to be developed in other areas where service type plans with adequate fee arrangements are provided to preferred risks. If the local societies want to do this and agree to it, there is no reason for the state association to be concerned.

This has been a rather prolonged discussion, but your Council feels that we are at the crossroads and we in medicine must make major decisions. If we repudiate all that we have done in the past, we thereby deny the fact that prepaid medical insurance is proper. Then, to be consistent, we should withdraw from C.P.S., Veterans' Home Town Programs, "Medicare," Public Assistance and Cripppled Children's Care. Our alternative is to face the issue squarely and, as reasonable and intelligent members of society with a full realization of our responsibility to the public, our patients, resolve our present problems in a manner that befits the integrity of the profession and our proud record of humanitarian service! (Applause.)

REPORT OF C.P.S. BOARD OF TRUSTEES

DR. T. ERIC REYNOLDS, *President*

Mr. Speaker, members of the House, and guests:

This past year has been a busy one for California Physicians' Service, a year characterized by changes and challenges. This will be a short report in which I will attempt to put in capsule form the principal items which have concerned us and which I hope will interest you.

C.P.S. continues to have good physician support, as it should. There has not been a year since World War II in which the physician membership has failed to show an increase. Physician membership now stands at 13,767, a net gain of 109 over a year ago.

When C.P.S. was organized in 1939 by the C.M.A., one of the objectives set forth by its founders was that of providing a method by which the medical profession might provide medical care for special groups. In this way organized medicine has used C.P.S. when dealing with the government in the last ten or twelve years. Here is a "nutshell" review of such activities to date:

The first of such arrangements occurred in 1946 when the Veterans' Home Town Care Program was instituted. This program enabled a veteran with a service-connected disability to receive ambulatory care by a physician of his own choice in his own area, without traveling (sometimes for a long distance) to a government facility. C.P.S. was designated to administer this program for the physicians of California. This method of providing medical care has been helpful to, and popular with, veterans, largely because the program has been given the cooperation of the medical profession.

In December, 1956, the "Medicare" Program began here as a result of conferences between a committee from the C.M.A. and the Department of Defense. As a result, dependents of active duty servicemen can now receive in-hospital care by civilian physicians in nonmilitary hospitals. Once again C.P.S. was designated to act as the fiscal agent.

In each of these two instances the medical profession regarded these actions as forward steps by which further spread of the building of government hospitals was somewhat curbed. We believe that this is a sound medical principle and ultimately less expensive to taxpayers.

It was natural, therefore, that C.P.S. would again be called upon to act as fiscal agent by some counties when the Public Assistance Medical Care Program was instituted during this past year. Its functions are limited to receiving and processing bills and providing information, together with presenting complicated cases to county medical society review committees. These services are performed on a "no-profit, no-loss" basis as a public service. Thirty-five of the 58 county governments are availing themselves of this service. By an action of the Board of Trustees, no additional counties will be accepted for fiscal processing by C.P.S. unless specific request is made by both the county supervisors and the medical society of the county concerned. Functioning as a fiscal agent, C.P.S. can accumulate statistical data which we think will be of great value in the years to come. There is a distinct division of opinion regarding both the necessity for and the philosophy of contracting with the government to provide medical care for certain segments of the population. This is a matter for the considered judgment and decision of the House of Delegates. In any case, when the help of C.P.S. has been requested by medical organizations, it has been able to provide technical information and implementation.

Five years ago the Board of Trustees established a subsidiary corporation which is licensed to sell indemnity insurance. California Physicians' Insurance Corporation was incorporated in 1953. Approximately another year was required in securing approval from the California Insurance Department for specific policies. Some encouraging progress has been made, particularly in the last six months. This is a highly competitive field and when such coverage is required, buyers usually look to the commercial insurance industry for this product. So far the largest group which has purchased indemnity insurance from California Physicians' Insurance Corporation is the employees of Butte County, with approximately 400 persons.

Besides indemnity plans, this wholly owned C.P.S. subsidiary is offering two other plans. One is a major medical policy which becomes effective after the basic contract benefits are exhausted and after a deductible or "corridor" payment, usually set at $100, is made. The second offering by California Physicians' Insurance Corporation is a comprehensive deductible policy which pays, as an example, 80 per cent of the specified costs as soon as the contract holder has accumulated $100 of deductible medical expense. This type of major medical insurance is not based on any basic service coverage. The Relative Value list is being used in establishing fee schedules. It is fair to state that the subsidiary corporation, CPIC, has a somewhat brighter outlook than it has had heretofore.

Community rating versus experience rating continues to be a vexatious problem for all Blue Shield Plans. The natural tendency has been for commercial insurance carriers to select preferred risks, thereby leaving an important section of the people with the dilemma of having to pay more money for the same coverage, or accepting less coverage. It works like a cream separator. It is natural for any group to want the plan which offers the most benefits for their money. Larger groups are normally better risks and take advantage of the lower rates offered them. Smaller groups and individuals are adversely affected by this process. Whereas C.P.S. originally used the community rating concept which is basically the best for all people, it has been forced by competition to adopt experience rating for some, usually larger groups.

Very few commercial carriers offer any coverage for persons who are being retired. As the facts stand today, the Blue Shield and the Blue Cross plans are substantially the only programs through which it is possible for all subscribers to continue to receive protection when they retire due to age or leave work for other reasons. C.P.S. receives many letters of inquiry from people who are concerned that they might lose their protection when they need it most. Through the continued membership plan we can offer benefits which will not be cancelled because of age or heavy utilization of benefits. This feature has recently been of greater and greater interest to both management and labor and because of the spotlight which is now being turned on health insurance programs for the older age groups, it is a problem which will require the utmost in careful study and scrutiny by the medical profession, and particularly by its insurance "right arm."

Increasingly in recent times C.P.S. has emphasized the acquisition of individual members, as well as small groups, thereby offering protection to persons who might not otherwise be able to participate in prepaid medical care. Emphasis will continue in this area in the coming year.

During the year your Blue Shield Plan paid out more money for member benefits than ever before. It was necessary to dip into reserves in order to meet these obligations. Shortly after the annual meeting last year claims costs rose at an even faster rate than had been projected. Comparing our experience with that of other Blue Shield and Blue Cross plans as well as those of commercial carriers, we found that our situation was generally no different than that of other prepaid health plans throughout the country. Increased costs of hospitalization and greater utilization of benefits are the two main reasons for higher costs. The costs of hospital care reached an all-time high last year, and more C.P.S. members used their benefits, for one reason or another, than ever before. Even though California Physicians' Service is a nonprofit organization, it must remain solvent and have adequate reserves. Therefore, it was necessary to adjust dues. At the same time that contracts were converted we revised underwriting requirements by insisting on 75 per cent participation of individuals within groups in order to avoid self-selection against the carrier, which results in high loss ratios. Through these actions the stabilization reserves have been increased, so that once again they are in general agreement with the recommendations of the National Association of Insurance Commissioners.

The Board of Trustees has received many inquiries concerning a change in C.P.S. fee schedules. The last major change—there have been minor changes in the interim—took place when the B Schedule was adopted in 1955 to apply to the $6,000 income provision. On March 31, the last day of the fiscal year on which I am reporting, C.P.S. received word from the Los Angeles County Medical Association that the association had adopted a $5.00 coefficient based on the California relative fee list to apply to a new $7,200 income provision. Some of this new

type of insurance is already in force. It is impossible to predict whether other counties will also wish to adopt this schedule at this point. If this is done, however, and the plan is purchased by most C.P.S. groups, it will eliminate, to a large extent, the complaints concerning inequities in the present schedule.

Because there is constant confusion on one point, it might be well to repeat this fact: Fee schedules are set by a C.M.A. committee, not by the C.P.S. Board. The Board's responsibility is to make sure that new schedules or proposed changes in existing schedules are within the ability of C.P.S. to meet and remain financially sound.

There has been great enthusiasm this last year by some physicians as well as by the insurance industry over the growth of major medical and comprehensive deductible plans. The Board has undertaken considerable study and discussion of the long-term effects of such programs. We share the opinion of many leaders in the insurance industry that an objective examination is now necessary, based on experience to date. This is now being done by insurance companies, but needs to be done also by Blue Shield plans. Physicians have a great responsibility as well as an interest in the ultimate future of this kind of protection.

C.P.S. now has a continuing study committee. Some members of the committee are from within the Board. Others are physicians who are recognized as students of the problems of medical insurance. It is my hope and considered opinion that this committee will serve, along with the other excellent committees of the California Physicians' Service, to continue to acquire and digest the rapidly changing aspects of this problem and continue to advise the medical profession on the best course of action to pursue.

I should like to take this opportunity to thank the members of the Board of Trustees for their valued and loyal support and to thank the many physicians of California who have made representations to C.P.S. in a sincere, constructive and earnest effort to improve its performance. I should also like to thank the administrative staff of the organization for its excellent performance, oftentimes requiring time spent beyond the usual call of duty. I believe that they have well earned a commendation for a job well done.

In closing, I would like to repeat some remarks I made a year ago. Physicians are individualists by nature and training. That is how they function best and we would like to keep them so, insofar as possible. Blue Shield offers this opportunity within the framework of democratic processes. The old adage about free men governing themselves applies equally well to a free profession. Physicians should not be complacent worker-ants in a medical ant colony, whether doctor-sponsored or not. In my opinion, at least, no one has suggested a satisfactory basic substitute for the often maligned physician-patient relationship.

Blue Shield is organized medicine's device for reconciling new economic concepts with traditional, personalized medical care. If we continue to make it work, we may preserve the kind of medicine we would like for ourselves and our families. If we don't make it work, there are plenty of interested parties to take over. It is not a job done. It is a job only begun. It is a continuing challenge. It is a lifeline of free medicine. (Applause.)

REPORT OF THE CONSTITUTION STUDY COMMITTEE

DR. SAM J. MCCLENDON

Mr. Speaker, members of the House of Delegates and guests: The Constitution Study Committee came into existence as a result of Resolution 2 adopted by the 1957 House of Delegates.

This resolution, introduced by Doctor Joseph M. de los Reyes of Los Angeles, called upon the Speaker of the House of Delegates to name a committee which would include representatives of all existing Councilor Districts. It also assigned four specific areas of study to the committee. In compliance with this resolution, your Speaker named a committee of eleven members, one from each Councilor District. This committee was assisted by the Speaker and Vice-Speaker of the House of Delegates, who attended its meetings, by Mr. Hassard as legal counsel, and by John Hunton, executive secretary.

The committee received advance material in the form of maps showing Councilor Districts, statistics on individual county society membership and district membership, a survey of how other state medical associations handled matters similar to those assigned to the committee and a digest of the comments of numerous medical leaders in California, including many past presidents and other officers of this Association.

Two meetings of the entire committee were held. In addition, a four-man subcommittee was assigned the task of studying some of the items on the committee agenda, and this group held one meeting.

The four subjects assigned to this committee by the House of Delegates for study were (1) proportional representation on the Council of the Association for all Councilor Districts; (2) reevaluation of the necessity for continuing the so-called "gentlemen's agreement" on the rotation of elected officers of the association; (3) the desirability of reducing the size of the House of Delegates; and (4) the method of selecting Delegates and Alternates from

California to the House of Delegates of the American Medical Association.

These items will be treated individually in this report.

The members of this House of Delegates should bear in mind that additional studies of some or all of these matters have been made during the past year by others. A constitutional amendment introduced in the 1957 House of Delegates has been lying on the table for the past year and has been published several times in the official journal so that all members could study it. It addition, the Council of the Association retained a firm of management engineers to study the operations and the structure of the Association, including all four items which were assigned to this committee by your action a year ago.

This report is made with a knowledge of the proposals offered by the management engineers, Robert Heller & Associates, and includes a full consideration of the proposal for proportional representation made by the constitutional amendment which awaits your decision at this meeting.

The first item assigned to the committee was the consideration of proportional representation by Councilor Districts on the Council of the California Medical Association. As proposed in the constitutional amendment upon which you will vote later today, the theory of proportional representation would be approved; Councilor Districts 3 and 4, both embracing Los Angeles County, would be consolidated into one district; all other Councilor Districts would remain in their present areas, and Councilors-at-Large would be eliminated. The amendment would call for the election by the Councilor District delegates to this House of Delegates of one Councilor for each 1,000 active members in the district and would prohibit any Councilor District from electing at any time more than forty (40) per cent of the total Council membership.

The committee reviewed the present and the prospective size of the Council, and the areas from which its members would be drawn under the proposed constitutional amendment and agreed that, with one further amendment, it would support this proposal. The further amendment would add the words "or major fraction thereof" to the proposed representation of one Councilor for each 1,000 active members. If this further amendment were added and the present proposed amendment, as further amended, were adopted, the one change in the Council as proposed under the present amendment would be to add one additional Councilor from San Francisco and to make it possible for one additional Councilor to be added from Alameda-Contra Costa Counties within the next two or three years.

Since legal counsel has ruled that the further amendment proposed by the committee could not be introduced legally into this House of Delegates for action at this time, the committee intends to support and recommend adoption of the constitutional amendment which will be voted on later today. It will then, under the heading of New Business in this House, introduce its further amendment if last year's proposed amendment is affirmatively acted upon. If the amendment now lying on the table is not voted affirmatively today, the committee will then introduce under New Business a proposed constitutional amendment which will incorporate the proposals made last year, add the additional amendment voted by the committee and make a few technical additions in the interest of clarity. This amendment would then lie on the table until the 1959 session, at which time it would be acted upon.

The second item given to this committee for study was the consideration of removing any geographical consideration in the election of officers of the Association. Under the so-called "gentlemen's agreement" which has prevailed for a number of years, the House of Delegates has rather consistently elected a Speaker and a Vice-Speaker of the House of Delegates from the Los Angeles County area. At the same time, the Council, which elects its own officers, has regularly chosen its chairman and its Auditing Committee chairman, who may also be elected chairman of the Executive Committee, from among its members in the San Francisco Bay area.

Any such arrangement as this so-called "gentlemen's agreement" is obviously a matter of compromise and is not fixed by inclusion in the Constitution and By-Laws of the Association. In past years this type of agreement has been challenged in this House of Delegates by members from other areas of the state who have felt that these elective offices should be available to any worthy candidate, no matter from which county he came.

In considering this question the committee did not feel that a fixed and arbitrary basis for election of officers by geographical areas would be desirable. Rather, it was the consensus of the committee that these offices should be open for the candidacy of any qualified member, regardless of his geographical location.

Inasmuch as there is no fixed policy in this regard in the Constitution and By-Laws, there is nothing formal which this committee can suggest be amended. However, it is the considered opinion of the committee that the Speaker and Vice-Speaker of the House of Delegates should be elected without regard to their geographical location and that the Council, in selecting its own chairman and the chairman of the Auditing Committee, should he also be

named chairman of the Executive Committee, should follow the same principle. The committee believes that this principle, if followed, will contribute to a democratic administration of the Association's affairs and will make available to a greater number of members these official positions which carry with them prestige as well as responsibility.

On the question of the size of the House of Delegates, the committee considered arguments both pro and con. Those who favored retaining a large House of Delegates made the point that the more members there were in the House, the more there were to carry back to their constituents the details of what the House had accomplished. Those in favor of a smaller House pointed out that the present membership of 365 made this body unwieldy and, in fact, weighted the representation of the House in favor of some of the smallest societies, where a county society membership of possibly 12 members was entitled to two Delegates and two Alternates, or one-third of the entire society membership.

After considerable discussion, this question was resolved by the decision to recommend that each county society be represented in the House of Delegates by one Delegate and one Alternate for each one hundred (100) active members or major fraction thereof, with a minimum of one Delegate and one Alternate for each society. This would produce a House of Delegates of about 160 elected members, in contrast with 323 elected members at this time. With the addition of ex-officio members, including all members of the Council and the past presidents of the Association, a House of Delegates of 202 members would result. An amendment to the By-Laws to this effect will be placed before this House of Delegates.

The final item assigned to this committee was the method of selecting Delegates and Alternates to the American Medical Association. Discussion brought out the fact that the California delegation in the A.M.A. has been extremely influential in recent years and that every effort should be made to maintain that status.

It was the consensus of the committee that Delegates and Alternates to the A.M.A. represented the entire state and that the capacity of a member to give such representation was more important than the area from which he came. With this in mind, the committee agreed that nominations for Delegate and Alternate to the American Medical Association should be carefully considered before being placed before this House of Delegates. To assure the nominations of members whose qualifications would tend to fit them for such election, the committee voted to offer a By-Law amendment to provide for formation of a nominating committee to make nominations for each office of Delegate or Alternate to the A.M.A. This committee would consist of two members of this House of Delegates, two members of the Council and two of the present Delegates to the American Medical Association. The Speaker of this House would serve on the committee ex-officio, with authority to vote in case of a tie. Additional nominations would also be permitted from the floor. A By-Law amendment to accomplish this purpose will be before you for decision at this meeting.

As a final suggestion to this House of Delegates, the committee voted to recommend that a redistricting of the state be undertaken, to provide proper and proportional representation on the Council for each district. To accomplish this, the committee recommends that the Speaker of the House of Delegates name a committee to consider such redistricting in the coming year and to present its recommendations to the House at the 1959 Annual Session.

As chairman of the Constitution Study Committee, I wish to thank each of the members who gave thoughtful and serious consideration to the matters placed in the committee's hands. The committee members were, from the First District, your chairman; Carl Hadley from the Second District; Marden Alsberge and Jay J. Crane from the Third and Fourth Districts; James Moore from the Fifth, Robb Smith from the Sixth; Leslie B. Magoon from the Seventh; Matthew N. Hosmer from the Eighth; C. J. Attwood from the Ninth; Fred Olson from the Tenth and James Yant from the Eleventh District. (Applause).

REPORT OF COMMISSION ON PUBLIC POLICY

DR. DAN O. KILROY

Mr. Speaker, members of the House of Delegates:

My report will be a report of the Committee on Legislation, and will not cover the subject of public relations, which is one of the committees under the Commission on Public Policy.

Your Legislative Committee has been concerned, during the present year, with the activities of many committees of the California Legislature; with the current budget session of the Legislature and with the election of legislators and constitutional officers of this state. During this same time your Legislative Committee has attended meetings too numerous to mention with other committees of the California Medical Association, with various departments of the state and with Legislative Interim Committees.

Mr. Ben Read, executive secretary of the Public Health League, and Mr. Gene Salisbury, assistant executive secretary of the Public Health League, have attended all such meetings and in addition have

met with the various county societies and have attended meetings called in the various councilor districts for the purpose of explaining legislative problems as they affect medicine.

As you know, regular sessions of the Legislature are held in each odd numbered year and only during regular sessions may general legislative bills be introduced by the assemblymen and senators. In even numbered years, such as this year, the primary problem is a study of the state budget and only with the consent of the Governor may other legislative matters be introduced during the budget session.

One such item introduced and passed during this budget session is AB 6, the so-called diploma mill bill, which will be discussed in more detail later by Mr. Salisbury.

There are numerous budgetary items such as the budget of the Department of Public Health, the Department of Mental Health, the Board of Medical Examiners and others in which medicine has a very vital interest, and such budgetary items are watched with considerable care during the budget session.

It has been our observation that political medicine is becoming extremely complex and the effect of many apparently unrelated actions will in reality bring about important changes in the manner in which we may practice medicine in the future. For example, a judge in a small northern county renders a decision in relation to the staff rules of district hospitals—a decision of vital importance to the doctors of California. On the other side of the picture is the action of chiropractors in Riverside and San Bernardino counties in forming a chiropractors' union affiliated with the AFL-CIO. Why was such a union formed? The president of this chiropractors' union said, "Most of our patients are working people. By joining the AFL-CIO we can help with their union, health and welfare funds."

Medicine is cognizant of ever-increasing pressures from many directions to change the manner in which medicine is now practiced. We are told that no question is being raised as to the scientific portion of the practice of medicine: Most individuals and organizations concerned appear to accept the calibre of medical care as being generally excellent. Yet many of these same groups tell us that the economic distribution of medical care is unsatisfactory and that drastic changes will be required to produce a more efficient method of delivering medical services to the consumer.

Nelson Cruikshank, health insurance consultant for the AFL-CIO, has been quoted as saying: "We believe a union should try for a direct-service health plan, such as the Kaiser plan in California. If it can't get such a plan, the second-best sort of program is service coverage with an income ceiling such as Blue Shield offers. Last choice of all is an indemnity plan."

He further stated: "Our basic quarrel with the individual doctor is that he refuses to recognize he's a layman in economics. He may be even worse than a layman; he may be an illiterate. That's partly because his intensive training in medicine deprives him of the broader education a lot of other people get."

The manner in which medicine will be delivered and paid for in the future will become a matter of legislative concern unless medicine brings forth an acceptable answer to this problem. I need not point out that government at the local, the state and the federal level is interested, as a third party participant, in the economic distribution of medical care. Inasmuch as government represents the people it is obvious that the people have an interest in this problem. If medicine does not develop an equitable and acceptable answer to this economic problem the answer may be provided for medicine through legislation which might, in the end, be quite unpalatable.

The expressed attitudes of many legislators indicate some of the influences which will be brought to bear, in the future, upon your practice and mine. It appears that the further removed an elective official is from his constituents the more he appears, in the eyes of many, to lean toward measures of a socialistic nature. Many legislators appear to have a platform favoring motherhood, opposing sin and proposing the socialization of the practice of medicine. Perhaps the best known such measure is one introduced by Representative Aime J. Forand of Rhode Island (HR 9467). Senator Wayne Morse of Oregon recently jumped on this same bandwagon and, with a flourish of publicity, introduced a companion measure to the Forand Bill in the United States Senate. It is of interest to observe that the federal social planners, although they have not given up their plans to develop a social economy, have apparently become more patient and they appear content to approach their goal from many different directions. There is certainty that government will continue the present concept of paternalism toward the aged, the disabled and the deficient. There will be continuing legislative proposals, many of which will be medical in nature.

Medicine must now decide what attitude it will hold toward these various anticipated legislative proposals. Will we reject all pieces of legislation in the future in which government acts as a third party or will we instead establish a set of principles by which we can judge such future measures, recognizing that some of these proposals can be com-

patible with established basic principles of medical practice while others so violate those principles that they must merit the full opposition of that collective body known as medicine.

All future governmental medical plans, in which government has a third party interest, will undoubtedly arise in Washington, D. C. These will then be presented to the various states as grants-in-aid; and once this legislation has passed the federal level little can be done at the state level to turn back the tide of social legislation.

It thus becomes the responsibility of each physician, and through him the responsibility of each higher medical echelon to devise a set of principles by which such future legislation may be judged and to further decide whether medicine will or will not oppose any specific legislative proposal when it is measured against this rule of basic medical principles.

Medicine must further recognize that at the Washington level the voice of the doctor has been lost. We are repeatedly told, even by our legislative friends, that the American Medical Association, as a legislative organization, has become ineffective. This lack of ability to bring the problems of medicine to the attention of our senators and congressmen will cost us dearly in the future. A continuation of these same ineffective methods will produce further social medical legislation by the now unopposed do-gooders. Now is the time for decision and that decision must be made by the individual physicians.

The doctors of California have evidenced an increasing interest in legislation and legislative matters during this past year, and that increased interest has been both helpful and appreciated by your Legislative Committee. Without the interest and cooperation of each individual doctor your legislative program cannot hope to be successful. You cannot, by the passage of resolutions or the formation of committees, delegate this responsibility to others. Only through the individual and self-sacrificing efforts of each physician can we hope to continue an effective voice in Sacramento.

The chairmen of the legislative committees of the various county societies have been most helpful in carrying out your wishes. On April 19 and 20 of this year the legislative committees from the northern and southern portions of this state met for a discussion of the various candidates for Assembly, Senate and constitutional officer positions, and evaluation of the various candidates was done based upon the desires of the doctors in the various areas represented. From that meeting your committee received instructions so that we may, at the coming elections, carry out the grass roots intent of supporting your friends and leaving your enemies at home.

I wish to recognize at this time the members of the C.M.A. Legislative Committee, bringing them to your attention so that you may express your appreciation for the many hours of hard work which they have given in your behalf.

Dr. Justin Williams of San Francisco has represented the Bay Area for some long time on your Legislative Committee and has been of marked assistance to your committee and to the doctors of the Bay Area.

The other member of the C.M.A. Legislative Committee, Dr. J. Lafe Ludwig of Los Angeles, has been for many years a tireless worker for medicine. Dr. Ludwig, a member of the Legislative Committee of the California Medical Association is, as well, a member of the Legislative Committee of the American Medical Association.

Mr. Speaker, with your permission, I would like at this time to have Dr. Ludwig address this House of Delegates, speaking to you on national medical legislation.

DR. J. LAFE LUDWIG: Mr. Speaker, members of the House of Delegates of the California Medical Association: The Number One target of the A.M.A. legislation is the defeat of the Forand Bill and similar types of legislation. I use the latter part of that sentence advisedly, because there are some twelve bills introduced along this line, some even worse, such as the Proxmire Bill. A similar bill has been introduced by Congressman James Roosevelt of California.

You know in line with the letter you received from Dr. Palm, including the pamphlet on the Forand Bill, that the Joint Council to Improve the Health and Care of the Aged has been formed. It is represented by four organizations, the American Medical Association, the American Dental Association, the American Hospital Association and the American Association of Nursing Homes. There were practically no statistics available to enable us to come to a conclusion in arriving at a positive approach in opposing this bill.

Now, to the best of our knowledge, social security legislation is going to be heard by the House Ways and Means Committee approximately May 15. That will include the Forand Bill. One member of the House Ways and Means Committee, Congressman King of California, sitting as a member of that committee, should be forwarded any communications that you have relative to that, because it is our sincere feeling that if this bill comes out of committee with the recommendation for passage, and goes to the floor of the House, it will be passed. We have had numerous congressmen say that they have received innumerable letters from members of

the medical profession, and that instead of imploring them to vote against the bill should it come to the floor, and stating the reasons they should vote against it, the letters have been nasty letters, as they put it. So I would ask that if you do write your congressman, you give him logical reasons for opposing it rather than derogatory letters.

I would again call your attention to the fact that the A.M.A. *Washington Newsletter* is available for every member of the A.M.A. by writing to Washington, requesting that you be put on the mailing list. I checked with the Washington office about three months ago, and whereas we have some 15,000 members of the A.M.A. in California, there were only 281 interested enough to write for the letter. At last report, there are now over 900 in the last 90 days. As you know, you can keep current with the legislative problems in Washington by looking through your *Journal of the American Medical Association.*

One other thing: In line with this breakdown of communication that your president referred to this morning. Whereas in the past I have had a key man to be in touch with each one of the 30 congressmen in the state, about a month ago at the meeting of the Legislative Committee of the California Medical Association, we decided to stop this duplication of effort and from now on each legislative chairman of each county society unit will be hearing from me. So it will be up to the county legislative chairmen to break down the list as to what congressman or congressmen serve in their particular area.

I am not going to say anything about the Washington office. I heartily concur in everything that has been said. I believe it should even be carried further.

Dr. Dwight Murray, former chairman of the Legislative Committee of the C.M.A., a past president, and now legislative representative of the Council of the C.M.A., will now speak on national medical legislative problems.

DR. MURRAY: Mr. Speaker, Dr. MacDonald, Dr. West, members of the California Medical Association: I am certainly glad to be here, always glad to be present at any meeting of the California Medical Association.

A few days ago, the new general manager for the American Medical Association called me and asked me to bring to this group his greetings and best wishes for a successful meeting, and also the greetings of other officers and Board of Trustees of the American Medical Association.

You should know, as Dr. Cass said to you a few minutes ago, that it is of importance to California Medicine to know what is going on in the national scene. I want to say to you this, that the actions taken by this House of Delegates are not only of great importance to the people of California, but of great importance to the people of the United States. In organized medicine, California is looked upon as being one of the leaders; the California delegation is looked upon as the most important and strongest delegation in the House of Delegates of the American Medical Association. They rightfully do that too, because it is one of the largest and most powerful delegations. As you well know, this is the second largest delegation. At present New York has as large a delegation as ours. The number of delegates from New York varies according to the number of members they have, but we are fast overtaking them. It won't be long until we will have not only the most powerful but the greatest number of delegates in the American Medical Association House of Delegates.

I want to emphasize everything that has been said with respect to legislation. From the remarks that Dr. Kilroy made, you can understand how important legislation is, and it is becoming more and more important as time goes on. I remember a good many years ago arising to tell you how important it was in California. If it was important then, it is more important now. We realize that, and have realized it in A.M.A. for some years, that the legislative program in Washington was of the most importance. We also recognize that it was not what it should be. Just a year ago, now, we were considering the Heller Report having to do with the reorganization of the American Medical Association. The reorganization of the Washington office from the legislative point of view was put over until this year. In the past the Washington office has not been as forcible as it should be. Since it came into existence, we have had three different directors. Now, as you know, Dr. Alpin has resigned. He has left the Washington office. His resignation takes effect the first of May. In his place temporarily will be Dr. Kinnard. Dr. Kinnard has been with the American Medical Association office for some three years. He is a very capable man, but it is not expected that Dr. Kinnard will be the permanent director of the Washington office.

You heard from Lafe Ludwig, and you heard from Dr. Cass about the setup of the legislative program of the American Medical Association. The Legislative Committee is made up of men who are chosen from geographical areas. That Legislative Committee meets and goes through all of the bills that are important to medicine and tries to give its ideas not only to the Board of Trustees but to the profession generally, and it is the duty and function of men on this Legislative Committee to see that

information is presented to the members of the profession. That is a tremendous job. It is not toward what the Legislative Committee has done so much as what it is trying to do in the future that the reorganization is planned. Dr. Blasingame said this to me on the telephone: "Will you talk to the members of the California Medical Association and see what their ideas are with regard to this reorganization. There will be nothing done officially until after the Congress adjourns."

It would be a mistake to try to change now in the middle of a very intensive legislative program. Therefore, at the meeting of the A.M.A. in San Francisco in June this problem will be very thoroughly discussed. I understand that the California delegation to the A.M.A. has some very constructive suggestions to make about the Washington office. What changes are made will depend entirely, I think, upon the wishes and desires and the suggestions that may be put forth by the various delegations that will be in attendance at the meeting in San Francisco. I want to say to you that whatever is done, it will be done only after the most serious consideration, because we realize the importance of the things that Dr. Kilroy, Dr. Cass and Dr. Ludwig have said to you. It is important to have a very strong legislative organization in Washington, and we realize that if we do not have that, we are probably going to suffer more than we have in the past. By bills being passed that we do not like, we have suffered in the past.

Again, Mr. Speaker, I assure you of my appreciation for being here.

Thank you, Dr. Kilroy, for the opportunity of speaking to you once again. (Applause).

DR. KILROY: Mr. Speaker, Mr. Ben Read, executive secretary of the Public Health League, has again done his usual excellent job of representing medicine before the State Legislature and its various committees.

On behalf of the doctors of California, it is my privilege to express our appreciation to Ben for the undivided loyalty which he has given to the physicians of this state for these many years.

Mr. Vice-Speaker, with your permission, I would like to call on Mr. Read to present to this House of Delegates information pertaining to the coming elections in California.

MR. BEN READ: Mr. Speaker, members of the House of Delegates: As you all know, this is election year and, of course, as good citizens, we are all registered and are going to vote.

The primary election occurs June 3. At that time you will select candidates for United States Senator, 30 members of the House of Representatives, the Governor, the Attorney General and other constitutional officers. You will select twenty state senators and eighty assemblymen.

Some of medicine's good friends are retiring from the State Legislature, and others of your good friends face very tough opposition.

As Dr. Kilroy told you, the legislative chairmen of the county and district medical societies met with the Legislative Committee of the C.M.A. and representatives of the Public Health League, and information was given to them about candidates for the State Legislature, and these local chairmen were asked for their recommendations. This information has been passed along by these local chairmen to the members of your component groups.

Many of these contests will go into the final elections. It is not possible for them to carry it in the primary election as often as they used to, so in the fall we will have to do as in the past: Try to send our friends back and leave our enemies at home. (Applause.)

DR. KILROY: Mr. Gene Salisbury, assistant executive secretary of the Public Health League, a member of the team of Read and Salisbury, has again done his usual excellent work in representing the interests of medicine in Sacramento, for which we are all most grateful.

Mr. Speaker, with your permission, I would like to have Mr. Salisbury bring to the attention of this House of Delegates information pertaining to the various interim committees studying medical problems, and also information pertaining to the diploma mill bill.

MR. GENE SALISBURY: Thank you. Mr. Speaker, members of the House of Delegates: Dr. Kilroy has mentioned the diploma bill, Assembly Bill No. 6, that was placed on special call at the March session.

Now, this bill, which had our wholehearted support, is possibly one of the most beneficial bills that our organization has sponsored in a number of years. The bill as signed by the Governor and enacted into law provides for the prosecution (and carrying a felony conviction) of persons selling, bartering or purchasing a fake diploma.

Now, of equal importance are the regulatory provisions carried in the measure, which require the right of inspection under the State Department of Education, an annual inspection, and a reporting by all schools of their faculty, their students and their curriculum. This will be the first time in California's history that the State Department of Education has had the right and the obligation to inspect all schools of learning.

Now, because of our state's phenomenal growth, we find that legislation has become a twelve-month process, rather than a six-month or a one-month process in the even-numbered years. This is carried

on by the Interim Committees of both of the houses, the Assembly and the Senate. Indicative of this process is the fact that there are now in operation 84 Interim Committees. There are perhaps 20 out of those that are of immediate and direct importance to our profession. Perhaps the most important is the Senate Committee on the Investigation of Cancer Quackery. That committee under the chairmanship of Senator Jack Thompson of San Jose, has held two meetings. Its next meeting is scheduled for May 6, 7 and 8 in San Francisco. At the San Francisco meeting, we are going to be privileged to hear from Mr. Harry Hoxsey, Mr. Leo Hoffward and Mr. Fred J. Hart. With the assistance of the Cancer Commission, your position will be propounded by Ray Kaiser, M.D., of the National Cancer Institute, Charles Goldberg, M.D., from Dallas, a pathologist, and Harry Garland, M.D., of San Francisco, radiologist. We anticipate an extremely lively and interesting hearing.

We think, from our observations of the committee's progress, that we should be able to anticipate a bill for recommendations that may be most acceptable to medicine. (Applause.)

DR. KILROY: Before completing the report of your Legislative Committee, I wish to again commend our legal counsel, Mr. Howard Hassard, and Mr. Bob Huber for the advice and help they have given so many times to your Legislative Committee. This liaison between the legal department and the Legislative Committee is so close that Hap Hassard is regarded as a member of the Legislative Committee without whose help your committee would be most ineffective. These services to medicine are rarely noted by the individual doctor, yet we are all in the debt of Mr. Hassard and Mr. Huber.

The Public Relations Department, through Mr. Ed Clancy, has given invaluable assistance and advice to your committee, and for this we are indebted and grateful.

Mr. Vice-Speaker, members of the House of Delegates, this concludes the report of the Legislative Committee.

REPORT OF COMMITTEE ON PUBLIC RELATIONS

DR. SIDNEY J. SHIPMAN

Mr. Speaker, members of the House: I also would like to commend Mr. Clancy and his staff for the excellent work they did on the Public Relations this last year. Our full-time staff is an excellent group.

I would like to call your attention to the printed report of the Public Relations Committee, appearing on pages 78 and 79 of the March issue of CALIFORNIA MEDICINE.

In it the committee has stated that "the success or failure of the public relations effort for the entire profession, how its high ideals of dedication to service of the public are interpreted, can best be measured in the California press; not by an inventory conducted by ourselves!"

That inventory, as noted in the reprinted editorials, has, for the most part, been highly complimentary.

And here again at our Annual Session, the public relations of medicine, how we are meeting our obligations to the people of California, is on display in open convention— our actions to be reported in the press and our decisions the probable subjects for editorial comment.

The best public relations efforts are never spectacular, since they revolve around services the profession has long since determined the public has a right to expect.

During the past year these obligations have been met with increasing understanding and efficiency.

Outstanding, of course, is the continued effort of all county societies and branches to perfect emergency medical care under circumstances as varied as is California's population, geography and climate.

Next in importance is the increase in activity of our Public Service Committees, where misunderstandings between doctors and patients may be reviewed and adjudicated. Physicians everywhere, by their demonstrated integrity, have long since proved that these groups are not doctor-controlled, whitewash mechanisms.

One has only to attend a meeting of a County Public Service Committee to realize the determination of the profession to correct doctor-patient dissatisfaction found to be the fault of physicians. In this, of course, we are not entirely altruistic, because the results show that a misunderstanding that can be corrected within the Public Service Committee room never reaches the jury room of the court house.

In this field of the prevention of professional liability suits, your Public Relations Committee looks forward to cooperation with the Medical Review and Advisory Board.

Another dividend from active Public Service Committees is the furthering of the stability of the operation of voluntary insurance plans—major medical cost coverage being a case in point, where the prevention of abuses by either the patient or the physician is a prime requisite for growth of this comparatively new innovation in the prepayment field.

The many discussions of the operation of the controversial indigent care program have highlighted another of our basic public relations tenets,

to-wit: While a variety of resolutions are to be introduced on the subject; while there is disagreement on the operation of the plan, there is no deviation from our determination to care for these and other patients regardless of their inability to pay.

Reviewing these public relations accomplishments, as we have stated, is not spectacular.

What is spectacular is when one of us fails in his responsibility to the patient—to the profession!

That failure can be reflected upon the entire profession with such speed as to jeopardize a proud record of countless successful physician relationships.

That we've had but one minor breakdown during the past year is a credit to all. Particularly is it to the credit of the diligence and determination of county society officers and, in the larger areas, to the day-in and day-out "follow-through" on the part of the executive secretaries.

Your Public Relations Committee has had two successful meetings during the past year, at which we reviewed the operations of the Public Relations Department.

Because of the inter-relationships between Public Relations and Legislation, Dr. Dan O. Kilroy, chairman of the Commission on Public Policy, along with Mr. Ben H. Read and Mr. Gene Salisbury of the Public Health League, has attended these meetings.

Following the directives of this House, the Public Relations Committee has continued to work with students, residents and interns.

On March 30 of this year, in cooperation with the Los Angeles County Medical Association, we held the Fifth Annual Public Relations Conference for the Student A.M.A. members from USC, CME and UCLA.

On April 13 a similar meeting was held in cooperation with the San Francisco County Medical Society for the UC and Stanford students.

This program has been in operation a sufficient time to prove its effectiveness in that many of today's young physicians who are taking active parts in the affairs of their county societies received their first introduction to county and state functions at our early C.M.A.-sponsored Student A.M.A. meetings.

Newsletter, which is distributed each month to all C.M.A. members, members of the Auxiliary, medical students and all delegates from other states to A.M.A., has proved a valuable information medium. The committee received some personal satisfaction when the Medical Society of the State of Pennsylvania started an identical publication.

During the past year California physicians passed the four million mark in the distribution of pieces of public relations material to their patients. These C.M.A.-prepared messages telling of the physician's availability in case of an emergency, his explanation of fees and willingness to discuss them in advance of treatment, and his support of voluntary health insurance plans, together with the very popular Health Records, were submitted in competition to the American Public Relations Association. While the official announcements will not be made until May 2 at the Waldorf-Astoria, we are pleased to state that the California Medical Association will receive an Achievement Award when the judges submit their decisions.

During the year C.M.A.'s First Aid Charts were made available to all physicians. Orders have continued to come in from all areas, indicating physicians have found this is another valuable public relations tool to demonstrate interest in patients. The same goes for the Athletic Injury Charts. This C.M.A.-prepared chart is now on display in nearly every school in the state, and county societies have used it in connection with meetings with health educators and at athletic injury clinics.

Both charts have been widely copied throughout the nation.

This is again an election year. From the public relations standpoint, it is our hope that California physicians, working in close harmony with the Public Health League and County Legislative Committee chairmen will take an active interest in the support of candidates who understand our determination to preserve high standards of medical care.

The minutes of the February 8, 1958, meeting of the Council state:

"The Council shall establish policies relative to public relations and transfer such policies to a strong Committee on Public Relations which shall direct and supervise this activity."

Since the Council receives its directives from the House, we await your decisions. Once they are made, we have every confidence that your Public Relations Committee, acting with the continued fine support of the 40 component county societies, will carry them out to your complete satisfaction. (Applause.)

REPORT OF THE JUDICIAL COMMISSION

DR. DONALD A. CHARNOCK

Mr. Speaker, members of the House: The Judicial Commission with the aid of legal counsel is engaged in preparing a detailed statement on disciplinary procedures. This will be sent to each county society and will outline the steps to be followed in preparing disciplinary charges. The statement will outline the rights and privileges of members in preparing their defenses in disciplinary proceedings.

REPORT OF COMMITTEE ON REORGANIZATION

DR. FREDERIC EWENS

Mr. Speaker, members of the House: The resolution on Constitutional Amendment [No. 2] has been withdrawn. As to Resolution No. 24 that was presented to the House in 1957: The committee has considered the matter referred to it by the House of Delegates, and it is of the opinion that further time and study are required to arrive at a final conclusion.

It is therefore recommended that the committee be continued with the expectation that a formal report of its deliberations will be made at the next Annual Session of the House of Delegates.

RESOLUTIONS ADOPTED

Shown below are the resolutions adopted by the House of Delegates or referred to the Council or to committees of the Association. Where pertinent, the comments of the appropriate reference committee of the House of Delegates are appended.

PUBLIC ASSISTANCE MEDICAL CARE PROGRAM

Resolution No. 1.*

WHEREAS, The federal formula of permissive legislation to states on a dollar matching basis has created an apparently irresistible attraction to the majority of the states; and

WHEREAS, Resultant State Legislation (i.e. AB 679) appears to be founded more on the automatic appropriation of available funds than on such fundamental issues as the demonstrated need for such legislation; and

WHEREAS, There had indeed been no factual local demonstration of need for this program before the State Legislature; and

WHEREAS, Federal and state programs necessarily entail federal and state control in order to insure protection of the tax dollar with resultant loss of traditional local autonomy and responsibility to solve local problems, and

WHEREAS, AB 679 provides for and results in unreasonable and unnecessary dictatorial control of both patient and physician; and

WHEREAS, Any welfare medical program administered by national, state and county agencies with resultant multiplicity of controls results in heavy costs in the administration, and an increased tax burden; and

WHEREAS, The practice of medicine under AB 679 fails to maintain high ethical regard for all phases of medical care, violates privacy of patient and physician relationship, essentially abolishes patients self-respect and personal dignity, nullifies any effort to maintain family responsibility for care and fails to stimulate any honest effort on the part of the patient to carry as much as possible of his financial responsibility, and

WHEREAS, Economic problems concerning the provision of medical care for indigents and the elderly do exist which require the leadership and imagination of doctors both from humanitarian motivations and from the desire to maintain the private practice of medicine, and

WHEREAS, From time immemorial, physicians have cared for the indigent without thought of compensation and will always do so without government control or administration; therefore, be it

Resolved, That this House of Delegates go on record as rejecting the principles incorporated in AB 679 and that cooperation past and future in the care of the patient under this program in no way implies endorsement of O.A.S. and O.A.S.I.; and be it further

Resolved, That the House of Delegates of the California Medical Association instruct the Council to join with other interested groups in exerting maximal effort and full resources, and any other facilities to repeal Assembly Bill 679 and applicable Federal legislation; and be it further

Resolved, That recognizing that AB 679 is now law and recognizing the paramount obligation to protect the welfare of our patients, The House of Delegates urges that immediate steps be taken to improve the program and to eliminate existing defects in AB 679 and its administration, as follows:

1. Medical care programs be controlled and administered by the individual counties, with licensed physicians exercising through their organizations the degree of control over the appropriate agency commensurate with physician's responsibilities to the patient.

2. To expedite return of control to the county level, medical societies should cooperate fully with their local Welfare Board in administration of the program, in determining the needs of such a program and appraising the effectiveness of the screening of recipients and controlling any abuses of the program, and if possible, securing physician membership on the local Welfare Board.

*The resolution adopted was prepared by Reference Committee 3A as a substitute for twenty resolutions introduced on the same subject. These were originally numbered 1, 4, 10, 12, 13, 17, 21, 22, 24, 35, 36, 37, 38, 39, 55, 57, 65, 66, 69 and 72. The substitute resolution is shown here as No. 1 since that was the first of the series.

3. To accelerate return of control to the county level, various pilot programs such as the feasibility of the physician charging patients his usual fee without restriction, and other appropriate studies, at a local level, should be instituted without delay.

4. Removal of the prior authorization system to take place as soon as the present pilot program has developed information deemed adequate by the California Medical Association liaison committee.

5. That a uniform method of payment should be adopted, the most acceptable method of payment to be determined by a poll of California Medical Association membership.

6. That the officers, Council and Legislative Committee of the California Medical Association be instructed to urge the Governor to appoint one or more physicians to the State Board of Social Welfare.

ACTION: Adopted by House.

* * *

C.P.S. MEDICAL PERSONNEL

Resolution No. 2.
Author: Robert C. Combs.
Representing: San Francisco Medical Society.

WHEREAS, California Physicians' Service has in the past few years attempted to regulate the length of hospitalization of its subscribers; and

WHEREAS, The investigation of suspect cases has largely been conducted by *lay* personnel of California Physicians' Service; and

WHEREAS, Such personnel is not adequately trained to interpret medical reports and hospital records; and

WHEREAS, Decisions reached in this manner constitute an infringement on the practice of medicine, especially when the attending physician's judgment is questioned; and

WHEREAS, The physician is usually held responsible by the patient when all or a portion of the hospital bill is not paid by California Physicians' Service; and

WHEREAS, Other insurance companies in this field have rarely undertaken such police action in arbitrarily curtailing benefits anticipated by the patient and physician; and

WHEREAS, This type of solution to the problem of alleged unnecessary hospitalization has resulted in poor relationship between the patient and his physician, as well as between the physician and California Physicians' Service; and

WHEREAS, Most of these questionable cases could be easily resolved or clarified by a telephone conversation between the medical director of California Physicians' Service and the attending physician; now, therefore, be it

Resolved, That the California Medical Association House of Delegates request an immediate review of this practice by the California Physicians' Service Board of Trustees and suggest adequate medical personnel and more direct communication between its medical personnel and the particular attending physician.

ACTION: Adopted by House.

* * *

SAFETY BELTS

Resolution No. 3.
Author: Robert C. Combs.
Representing: San Francisco Medical Society.

WHEREAS, It is now known that the use of safety belts in automobiles effects a substantial reduction of death and injuries in crashes; and

WHEREAS, The number of persons currently killed or injured annually in automobile crashes is large enough to constitute a public health problem; now, therefore, be it

Resolved, That the House of Delegates of the C.M.A. urge the state legislature to make mandatory the installation and use of such belts in all new vehicles registered in California.

ACTION: Adopted by House.

(Comment by Reference Committee No. 3B: "The committee was made aware of the fact that the major automobile manufacturers are underwriting the costs of an investigation being performed by Cornell University into the problem of motor vehicle safety. The committee recognizes the broad aspects of this continuing problem which includes other safety devices such as recessed and padded dashboards, recessed steering columns and more secure door latches. The committee feels this is an excellent preliminary step in the direction toward highway safety . . .")

* * *

C.P.S. FEE SCHEDULE

Resolution No. 5.
Author: J. G. Middleton and J. Barry Smith.
Representing: San Luis Obispo County Medical Society.

WHEREAS, The C.P.S. fee schedule is recognized as a fee schedule acceptable to the members of the C.M.A. when in reality it is a substandard fee schedule; now, therefore, be it

Resolved, That this fee schedule be brought up to a realistic fee schedule.

ACTION: Adopted by House.

INDUSTRIAL ACCIDENT CASES

Resolution No. 6.
Author: J. G. Middleton and J. Barry Smith.
Representing: San Luis Obispo County Medical Society.

WHEREAS, Industrial accident cases represent people in a financially sound part of our economy and fees paid for such cases are substandard; now, therefore, be it

Resolved, That every effort be made to bring the fees up to a realistic level.

ACTION: Adopted by House.

* * *

PROTECTION OF THIRD PARTY INTERESTS

Resolution No. 9.
Author: Winston C. Hall.
Representing: San Diego County Medical Society.

WHEREAS, The continued interjection of a third party in the doctor-patient relationship is inevitable as long as prepaid health plans and government promoted programs continue to expand; and

WHEREAS, The third party must receive an assurance that a properly itemized bill will be furnished the patient and that any alleged abuses or questionable practices will not go unnoticed; now, therefore, be it

Resolved, That this House of Delegates of the California Medical Association instruct the Council of the California Medical Association to urge all county societies to offer where existent the use of review committees to all third party insurance carriers and government agencies so any unresolved disputes over medical services or fees may be heard: the purpose being to furnish authoritative information to enable third parties to take such action as is necessary to protect their rightful interest.

* * *

FEE SCHEDULES

Resolutions Nos. 14, 20, 26, 43 and 54.*
Author: C. E. Horn.
Representing: Sacramento County.

(Comment by Reference Committee No. 3: "Resolution No. 14 has to do with fee schedules; Resolution No. 20 has to do with a code of medical economics; the subject of No. 26 asks for a description of medical services and a dollar schedule of fees; No. 43 involves the principles of medical socio-economics and finally, No. 54, the Council resolution, involves the development of medical fees.

"It is the committee's opinion that all of these resolutions are concerned primarily with the development of principles of medical economics and have a common interest. It seems logical to this committee that all of these topics of necessity must be considered together. We therefore offer to you a substitute resolution.

"There has been an increasing clamor from the membership and the Council for a statement of policy, and in this substitute resolution we offer for the consideration of the House a solution to this complex problem.

"Within the context of this substitute resolution you will be referred to Resolutions No. 3 and No. 4 passed by this House of Delegates in 1954. I would like to read to you this action which was adopted.

"Resolution No. 3

***"RESOLVED,* That the California Medical Association proceed with vigor in the study, development and implementation of the Usual Fee Indemnity Plan.**

"Resolution No. 4

***"Whereas,* Many people are anxious to know in advance what their attending doctors' fees will be in order that they may secure adequate insurance or other means to pay those fees without worry about the financial problem at the time they need medical care; and**

***"Whereas,* Nearly all doctors already have fees which are their customary charges for the particular service involved; now, therefore, be it**

***"RESOLVED,* That the California Medical Association urge each of its members (a) to set up a list of his own fees, (b) to make this list known to his own patients, and (c) to assure his patients that he will make no higher charges except by agreement with the patient concerned before service is given.**

"It has come to the attention of the committee that many of the newer members of the House of Delegates may not be acquainted with the background of the Usual Fee Indemnity Plan. If it is the desire of the House, and you will so indicate, I shall be happy to ask the Speaker of the House for the privilege of the floor for a representative of Alameda-Contra Costa Medical Association. He will present a brief explanation of the Usual Fee Indemnity Plan which has been used successfully for the last five years in Alameda-Contra Costa County. This plan prompted the adoption of resolutions No. 3 and No. 4 of the 1954 House of Delegates.

"Mr. Speaker, I now present the committee's substitute resolution entitled 'Development of Principles of Medical Economics'.")

WHEREAS, The ever increasing interposition of third parties between physicians and patients threatens the existence of the private practice of medicine; and

WHEREAS, In the private practice of medicine it is the responsibility of the patient to pay the physician's fee; and

WHEREAS, Schemes of nationalization hinder the development of voluntary prepaid health insurance; and

*Doctor Horn is shown as the author of the first resolution of this series on the same subject. As shown above, Reference Committee No. 3 combined these into one substitute resolution which was adopted by the House of Delegates.

WHEREAS, Medicine has heretofore participated in the development of prepayment health insurance; and

WHEREAS, There is a need for the C.M.A. to reestablish its position in relationship to the economic aspects of private medical practice; and

WHEREAS, The C.M.A. Council urgently desires further and definitive guidance from the C.M.A. membership; now, therefore, be it

Resolved: 1. That it be reaffirmed that each physician is privileged to charge a fair fee for his services.

2. That each physician is to be guided by fees charged within his county or economic area.

3. That it is the responsibility of the local county medical societies to review when indicated the fees charged by their members.

4. That C.P.S. is the agency of the C.M.A. through which fixed service contracts are established.

5. That the House of Delegates reaffirm its support of the Usual Fee concept incorporating the principle of prior agreement as outlined in Resolutions No. 3 and No. 4 adopted in 1954 by this House of Delegates.

6. That another survey be made in 1958 of the fees charged by C.M.A. members and that annual rechecking surveys be made thereafter.

7. That in any discussion of doctors' fees it is recommended the current Relative Value Studies be used as a base with a factor determined by an annual statistical survey.

8. That any consideration of fee schedules incorporate free choice of physicians and fee for service.

ACTION: Adopted by House.

* * *

ADVERTISING

Resolution No. 16.
Author: Dave Dozier.
Representing: Eleventh Councilor District.

Resolved, The House of Delegates of the C.M.A. commends the Committee on Advertising of CALIFORNIA MEDICINE for its excellent work. It feels certain that this good work will continue; and be it further

Resolved, That this House of Delegates instruct the Delegates of the C.M.A. to the A.M.A. to introduce resolutions in the American Medical Association House of Delegates calling the attention of other journals sponsored by medical associations to the rules for advertisers published by the advertising committee of CALIFORNIA MEDICINE in the hope that the general level of professional pharmaceutical advertising in current literature may benefit thereby.

ACTION: Adopted by House.

(Comment of Reference Committee No. 3B: "Committee 3B is entirely in accord with the intent of this resolution. A printed set of rules for the guidance of advertisers was submitted to the committee, which found that the present rules for advertising in *California Medicine* are very commendable. The advertising committee for *California Medicine* is composed of a representative of the Food and Drug Administration together with practicing physicians of unquestioned repute. . . . It was realized that rules are only as good as the men who apply them. Your reference committee is confident that the present advertising committee has been doing a superb job. Members are invited to compare advertising in *California Medicine* with that in other journals in the United States. The committee therefore recommends the substitute resolution . . ." shown above.)

* * *

C.M.A. DEPARTMENT OF NEGOTIATIONS

Resolutions Nos. 25, 30 and 64.*
Author: Albert E. Long.
Representing: San Francisco Medical Society.

WHEREAS, The American people have expressed a desire for protection against the cost of illness in all age brackets; and

WHEREAS, We in medicine wish to preserve the traditional relation between physician and patient and to minimize the interposition of three parties; and

WHEREAS, In 1957 the House of Delegates passed the following resolution: "That the Council of the C.M.A. develop a department with adequate staff whose duty it shall be to represent the organized medical profession in negotiations with representatives of any and all groups which are designed to provide or control the furnishing of medical care to private citizens in this state"; and

WHEREAS, The C.M.A. Council has had this under study and has not been able to formulate guides for the most effective manner of negotiations with third parties; now, therefore, be it

Resolved, That the C.M.A. Council be directed to expedite the creation of a department to operate within the C.M.A. structure. Inasmuch as this department's scope of activity is purely economic it is recommended that it be kept separate from the administrative structure of C.M.A.; and be it further

Resolved, That the immediate problem of this

*Resolutions No. 30 and No. 64, also introduced from San Francisco, were combined with No. 25 in the substitute resolution shown here.

department shall be a study of the feasibility and propriety of developing a separate foundation to represent physicians in the fields of socio-economic research, study and negotiations; and be it further

Resolved, That whenever state or federal law requires development of methods and fees for the care of individuals by private physicians, it shall be the duty of the Council of the C.M.A. or its authorized representatives to review and advise in the development of such contracts for physicians who choose to participate or whose patients must participate and award or withhold Council approval.

ACTION: Adopted by House.

* * *

C.P.S. SEPARATE PREMIUMS

Resolution No. 27.
Author: Robert C. Combs.
Representing: San Francisco Medical Society.

WHEREAS, In the formulation of contracts under C.P.S., it has been difficult for the patient to distinguish that portion of the premium which represents the services of physicians from all other services; now, therefore, be it

Resolved, That in all contracts under C.P.S. management, each C.P.S. member will receive communications enlightening him as to what premium represents solely and exclusively the cost of services rendered by the attending physician.

ACTION: Adopted by House.

* * *

BASIC MEDICAL RIGHTS OF AMERICAN CITIZENS

Resolution No. 28.
Author: Albert E. Long.
Representing: San Francisco Medical Society.

WHEREAS, In the social trend toward organized programs for the purpose of obtaining protection against the unexpected costs of illness, various governmental agencies now act as third parties for the purpose of organizing and managing such programs, thus interposing themselves between physicians and patients; and

WHEREAS, Certain of these plans have resulted in the surrender to bureaucratic control of the freedom of action of the individual; now, therefore, be it

Resolved, That the House of Delegates of the California Medical Association approve the following principles:

We, as physicians of California, cognizant that the American citizen enjoys certain basic rights as his heritage, and that these rights extend to the citizen in his position as a patient, do hereby specify these basic medical rights:

1. He shall have the right to retain the physician of his choice, at office, home or hospital, and shall be free to terminate the professional relationship at his pleasure.

2. He shall have the right to the special skills and techniques of medicine, and to the advantages of consultation. His physicians shall have qualifications which have been determined by their peers, not by legislation; no governmental action shall create, to his detriment, first, second and third class physicians with first, second, and third class abilities, training, duties, or remuneration.

3. He shall have the right to know that his physician is responsible for all decisions regarding the extent of his medical care, and that these decisions are not dictated, restricted, or suborned by any third party. Nor shall legislative action or executive edict force his physician to regard him as a chattel, a number, or a head. It shall be recognized that any person covered by such programs is not medically indigent.

4. He shall have the right to know that the management of his medical program is efficient and open to inspection.

This House of Delegates instructs the Council and its representatives to maintain these principles as the basis for participation in any program of medical care, and instructs the delegates of the California Medical Association to the A.M.A. to press for immediate affirmation of this resolution.

ACTION: Adopted by House.

* * *

RELATIVE VALUE STUDY IN C.P.S.—SCHEDULES A & B

Resolution No. 29.
Author: Don C. Musser.
Representing: San Francisco Medical Society.

WHEREAS, In the report of the Commission on Medical Services a meeting was held with the executive committee of the Commission and the Executive Committee of the Board of Trustees regarding the possibility of bringing the C.P.S. Schedules A and B up to a level which more closely approximates current fees throughout the state; and

WHEREAS, It was agreed that, consistent with good business practices, the C.P.S. Board of Trustees will develop ways and means of increasing income levels so that the relative value study on a $4.00 unit basis can be eventually (even though gradually) implemented on the present Schedule A; and

WHEREAS, It was also agreed that consistent with

good business practices, the C.P.S. Board of Trustees will develop ways and means of increasing income levels so that the relative value study on a $5.00 unit basis can be eventually implemented on the present Schedule B; now, therefore, be it

Resolved, That the C.P.S. be instructed to adopt and implement the Relative Value Study in Schedules A and B.

ACTION: Adopted by House.

(Comment by C.P.S. Reference Committee: "The committee feels that since a changeover of C.P.S. fees to comply with the Relative Value Study as mentioned in the body of this resolution as being a gradual process and because this changeover now is already being studied by the Council and the C.P.S. Board of Trustees, and realizing it may consume some time, the committee does not feel that C.P.S. should be restricted by placing a definite time limit . . .")

* * *

CONFIDENTIAL STATUS

Resolution No. 31.
Author: Charles P. Lebo.
Representing: San Francisco Medical Society.

WHEREAS, The evolution of medical practice in recent years has complicated the classic concept of the physician-patient relationship by the addition of and interposition of certain third parties such as insurance carriers, governmental agencies, and legal practitioners and institutions; and

WHEREAS, Considerable confusion exists in the minds of physicians (and lawyers) concerning the ethical and legal aspects of the privileged communication as applied to physicians; now, therefore, be it

Resolved, That the Commission on Professional Welfare of the California Medical Association be directed to undertake a complete study of all phases of the confidential nature of the physician-patient relationship and render a report of their findings and recommendations to the House of Delegates of the California Medical Association at its 1959 annual meeting.

ACTION: Adopted by House.

* * *

HEALTH INSURANCE

Resolution No. 32.
Author: John F. Murray.
Representing: Fresno County Medical Society.

WHEREAS, Health insurance is of general interest to the public; and

WHEREAS, State educational facilities, especially colleges and universities, present curricula dealing with health insurance; and

WHEREAS, Faculty members have been known to emphasize or recommend certain aspects and types of medical insurance rather than presenting all conflicting viewpoints on the subject; and

WHEREAS, Many doctors of medicine in the California Medical Association and component county societies have had extensive experience in health insurance which qualifies them as competent consultants; and

WHEREAS, Such tax-supported educational programs should democratically present all views; now, therefore, be it

Resolved, That the House of Delegates instruct the Council to present to the governing bodies of tax-supported institutions of learning, means of having the medical profession act as qualified consultants in curricula and extra-curricular programs in order to provide democratic views on such educational programs.

ACTION: Adopted by House.

* * *

REIMBURSING PRESIDENT, PRESIDENT-ELECT

Resolution No. 34.
Author: Donald M. Campbell.
Representing: San Francisco Medical Society.

WHEREAS, Many deserving, desirable and younger candidates are unable to accept the nomination of President-Elect or President of the C.M.A. because of limited means; now, therefore, be it

Resolved, That the Council be authorized to allot to the President-Elect and President during their year of office a sum of not more than ten thousand dollars or one hundred dollars a day in excess of ordinary expenses while on C.M.A. business.

ACTION: Adopted by House.

(Comment by Reference Committee No. 3B: "Discussions before the Reference Committee indicated that there was divided opinion upon this subject. Apparently the question does not lend itself to resolution other than by a vote of the House. The committee gained the impression that the resolution was well received by the Delegates and the committee itself is in favor of the resolution.")

* * *

TAX EXEMPTION FOR MEDICAL EXPENSE

Resolution No. 40.
Author: Lewis T. Bullock.
Representing: Los Angeles County Medical Association.

WHEREAS, The Federal Government allows an exemption on the income tax for medical expenses up to $10,000.00; and

WHEREAS, The State of California restricts exemptions on income tax for medical expenses to $2,500.00; and

WHEREAS, The person with very high medical expenses is the one who most needs complete exemption for his medical expenses on his income tax; now, therefore, be it

Resolved, That the Officers, Council and Legislative Committee of the California Medical Association be instructed to take all necessary action to induce the State of California to make exemptions from income tax for medical expenses in California the same as accepted by the Federal Government.

ACTION: Adopted by House.

* * *

WASHINGTON OFFICE OF A.M.A.

Resolutions Nos. 41 and 70.*
Author: Edward H. Crane.
Representing: Los Angeles County Medical Association.

Resolved, That the A.M.A. be asked to make an immediate reevaluation of the functions of the Washington office of the A.M.A. and to institute such changes and other modifications or new approaches as may be necessary to provide medicine with effective public and government relations.

ACTION: Adopted by House.

* * *

NATIONAL LIBRARY OF MEDICINE

Resolution No. 44.
Author: William F. Quinn.
Representing: Los Angeles County Medical Association.

WHEREAS, Funds will doubtless be provided by the Congress of the United States for construction of an appropriate building to house the National Library of Medicine; and

WHEREAS, Recent weather damage has made emergency repairs on the existing structure imperative; therefore, be it

Resolved, That the rich heritage of the National Library of Medicine be protected and maintained by giving this project the highest priority; and be it further

Resolved, That copies of this resolution be forwarded to the appropriate senatorial and congressional representatives from California.

ACTION: Adopted by House.

*Reference Committee combined these two resolutions into the substitute resolution shown above, which was adopted by the House of Delegates.

EMERGENCY FACILITIES AND THE PHYSICIAN

Resolution No. 45.
Author: Fordyce Johnson.
Representing: Los Angeles County Medical Association.

Resolved, That the Council of the California Medical Association continue to sponsor a widespread educational program among physicians and the public emphasizing the role of the personal physician in emergency as well as routine and preventive care and urging selection of such a physician before the need arises.

ACTION: Adopted by House.

(Comment by Reference Committee 3B: "For many years there has been an educational campaign among physicians and the public recommending the selection of a personal physician. This resolution amplifies the subject by placing emphasis on the desirability of such a relationship before the existence of an emergency.")

* * *

PATIENT RESPONSIBILITY IN MEDICAL CARE PLANS

Resolution No. 46.
Author: Paul Hoagland.
Representing: Los Angeles County Medical Association.

WHEREAS, Socio-economic changes in our society have resulted in increasing third party participation in the distribution and control of Medical Care; and

WHEREAS, Such third party participation may improve the distribution of Medical Care through the principles of pre-payment and insurance; and

WHEREAS, The serious danger in such third party participation is the threat of lowered standards of quality (due to interference with the feelings of personal responsibility of the physician for his patient, and the patient for sound and economical use of medical services); and

WHEREAS, Personal responsibility of both the physician and the patient are encouraged if the patient has a continuing financial interest in his medical care (through the use of deductibles, co-insurance, and policy restrictions controlling injudicious demand for medical services); now, therefore, be it

Resolved, That the California Medical Association adopt the policy that no future proposal for third party participation in the distribution of Medical Care (whether by government plans, medical service plans, insurance companies or other agencies) will receive unqualified endorsement unless such proposal contains adequate provisions for continuing patient financial participation in his medical services, as by the use of deductibles, co-insurance, and other reasonable restrictions.

ACTION: Adopted by House.

(Comment by Reference Committee 3B: "A number of health insurance policies embracing this principle have already been written, covering a great number of beneficiaries in industry. The principle of deductible insurance has been thoroughly understood and accepted in the automobile insurance field.")

* * *

TAX DEDUCTION FOR TUITION COSTS OF HIGHER EDUCATION

Resolution No. 47.
Author: William F. Quinn.
Representing: Los Angeles County Medical Association.

WHEREAS, Ever increasing federal and state taxes are becoming more burdensome to the average citizen; and

WHEREAS, The United States Government recognizes the need, necessity and requirement of higher education and training in the scientific and professional fields; and

WHEREAS, The tuition costs and fees of students maintained in state supported universities are less than tuition costs and fees of students in private supported universities due to subsidy by tax funds; and

WHEREAS, The tuition costs and fees of students maintained in private institutions of higher education are entitled to benefits and considerations equal to those of a student maintained in a subsidized state university; and

WHEREAS, The tuition expense and fees incurred by a student attending a private institution of higher education should be deductible to the taxpayer to offset and equalize the subsidy granted the student of a state supported university; now, therefore, be it

Resolved, That the House of Delegates of the California Medical Association urge the legislative committee of the American Medical Association and Members of Congress, from the State of California, and members of the State Legislature of the State of California, to take such steps to initiate or to have introduced into the Congress of the United States and the Legislature of the State of California, legislation which would have as its object as allowing all items incurred in the maintenance of a student in a recognized college or university for tuition or fees as a deductible item in the computation of gross income for federal and state income tax purposes.

ACTION: Adopted by House.

(Comment by Reference Committee No. 3B: "Reference Committee 3B considers that there is much merit to this suggestion . . .")

NURSE TRAINING PROGRAM

Resolutions Nos. 49, 50 and 51.*
Author: Robert Dennis.
Representing: Santa Clara County.

WHEREAS, It is fundamental that the medical profession and the public are deeply concerned with good, sound nursing care for the sick and injured, and thus believe in modern training programs for nurses assuring such care; and

WHEREAS, Many leaders in the field of nursing education have altered the nursing program of training so that future graduates of nursing will be poorly equipped for the care of their patients because of overemphasis on academic training and because of limited necessary practical experience; and

WHEREAS, It is believed that the medical profession at county, state, and national levels, could be of great assistance to the nursing profession, in planning programs of training which would be consistent with nurses' needs and dignity, while at the same time assuring physicians and the public of experienced and well-balanced nursing care; and

WHEREAS, Recent training programs have not utilized the recommendations of the medical profession; now, therefore, be it

Resolved, That the C.M.A. Council initiate continuing discussions with representatives of the California Nurses Association, California League of Nursing, the California Board of Nurse Examiners, the California Hospital Association, and all other interested groups, to resolve the inadequacies in quality and quantity of nurse training. The results of such discussions shall be disseminated to the medical profession through reports to the county medical societies and editorialized in CALIFORNIA MEDICINE; and, be it further

Resolved, That the Delegates to the A.M.A. be instructed to request similar conferences on the national level.

ACTION: Adopted by House.

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*Reference Committee 3B combined these three resolutions into a substitute resolution shown above. The committee commented that it was "appalled to learn that the advice of highly competent and esteemed physicians on advisory committees and the California State Board of Nursing had been ignored to such an extent that it frequently became difficult to enlist the services of competent physicians to serve in these capacities, which had now become such chores."

EMERGENCY AUTOMOBILE INSIGNIA

Resolution No. 52.
Author: Leon P. Fox.
Representing: Santa Clara County Delegation.

WHEREAS, The Medical Profession of California is finding it more difficult to reach patients who are in need of emergency care, because of an increasing traffic problem; and

WHEREAS, The safety of the physician during emergency travel is lacking under present conditions; and

WHEREAS, The traffic patrolmen, who are already very cooperative, should be able to identify the emergency physician immediately and should through enabling laws be permitted to allow him to pass conventional blocks and obstructions undetained; now, therefore, be it

Resolved, That the Council of the C.M.A. be directed to take necessary action to amend the California Motor Vehicle Code authorizing doctors of medicine to have special, standard, properly lighted, emergency signal markers on their automobiles, and that all police be directed to recognize them.

ACTION: Adopted by House.

(Comment by Reference Committee No. 3B: "With the increased density of population and traffic congestion the problem outlined in this resolution becomes more and more onerous. Resistance has been encountered, however, when similar insign'a have been desired in the past. This resolution calling for amendments to the California Motor Vehicle Code approaches the problem logically because uniform statewide adoption of the insignia must necessarily be by a legislative process which will declare physicians' cars as emergency vehicles and accurately delineate privileges conferred and penalties inflicted for their violation and abuse.")

* * *

FACULTY PRIVATE PRACTICE

Resolution No. 53.
Author: Clyde L. Boice and Burt L. Davis.
Representing: Santa Clara County Delegation.

WHEREAS, The Council of the C.M.A. appointed a Special Committee on the Private Practice of Medicine by Medical School Faculty Members in 1956; and

WHEREAS, The resolution recommending establishment of this committee requested yearly reports; and

WHEREAS, The 1957 report of this Special Committee was enthusiastically received by this House of Delegates; and

WHEREAS, The C.M.A., as an organization and through its individual member's efforts, has evidenced its interest in the welfare of California's Medical Schools; and

WHEREAS, We have not been informed of the attitudes of the various medical schools toward the recommendations contained in the Special Committee report; and

WHEREAS, As an organization and as individuals, we are interested in the attitudes of the medical schools; now, therefore, be it

Resolved, That the Special Committee on the Private Practice of Medicine by Medical School Faculty Members be instructed: (1) To meet with representatives of the medical schools and determine their attitudes toward this committee's report of 1957, and (2) annually to report its continuing findings to the House of Delegates.

ACTION: Adopted by House.

(Comment by Reference Committee 3B: "It has been quite apparent that a serious problem exists in the private practice of medicine by faculty members of medical schools or other physicians whose facilities are provided for them by tax-supported or by private institutions. The Council on Medical Services of the American Medical Association made a thorough study of the conditions and practices as they existed nationwide. The House of Delegates of the C.M.A. resolved in 1956 that such a study should be made by the California Medical Association. A special committee was appointed, chairmanned by Dr. Dwight Wilbur. The excellent report of this special committee was accepted by this House of Delegates in May of last year and became a basis of policy of the California Medical Association. Its urgency was emphasized by the fact that it was reproduced shortly thereafter in the July, 1957 issue of *California Medicine*. The response of medical administrators to the principles outlined in this report is of great interest to many physicians. Section III of the report states: 'The resolution referred to the Council by the Delegates last year (1956) requested that yearly reports be rendered by this committee. This, then, is our first report.'

"No second report has been forthcoming. The Reference Committee has been informed that this committee has held no further meetings. The adoption of this resolution, therefore, appears most timely.")

* * *

SOCIALISM

Resolution No. 58.
Author: Frederic P. Shidler.
Representing: San Mateo County Medical Society.

Be It Resolved, That the California Medical Association recognize government financed and administered medical plans as no different from governmental monopolistic operation of any industry; and be it further

Resolved, That the officers of the California Medical Association decline to bind its individual or

collective members to any agreement with a bargaining third party, and be it further

Resolved, That the California Medical Association assert its belief in democracy, warn its membership of the deeply entrenched position of power with which all forms of government surround its electorate, and declare its support of intellectual and economic freedom for all men, including physicians.

ACTION: Adopted by House.

* * *

CANCER QUACKERY LEGISLATION

Resolution No. 59.
Author: John W. Cline.
Representing: Cancer Commission.

WHEREAS, Legislation designed to combat cancer quackery and at the same time provide security for the freedom of research and the legitimate practice of medicine was introduced into the last session of the Legislature and received widespread support; and

WHEREAS, This matter was referred to a Senate Interim Committee for further study; and

WHEREAS, This Committee has held hearings, issued a progress report and will hold further hearings; now, therefore, be it

Resolved, That the California Medical Association express its appreciation and commendation to the Interim Committee for the fair, conscientious and thorough investigation in its undertaking; and be it further

Resolved, That the House of Delegates reiterate the opinion of the California Medical Association that legislation to curb cancer quackery is urgently needed; and be it further

Resolved, That the California Medical Association respectfully suggest to the Interim Committee that it give consideration to the following principles in the formulation of legislation.

1. A Cancer Council appointed by the Governor, composed in the main of physicians and surgeons and including members of the faculties of the schools and colleges in California granting degrees leading to licensure as physicians and surgeons in this state, be created within the Department of Public Health.

2. The Cancer Council should have the following responsibilities:

(a) To investigate and evaluate any drug, material, device or method used in or purported to be used in the diagnosis or treatment of cancer.

(b) To require that the Council be provided with samples of any drug, material or device in amount ample for investigation and all information pertinent thereto. Refusal to comply with a request of the Council to do so shall constitute a punishable infraction of law and in applicable instances shall constitute unprofessional conduct within the meaning of the Business and Professions Code.

(c) To hold hearings and to subpoena persons and documents for the purpose of its investigations.

(d) To make a finding of scientific fact as to the value or lack thereof concerning any method, drug, material or device used in the diagnosis or treatment of cancer.

(e) If after full and impartial hearing, any drug, material, or device be found to be harmful, lacking in value, fraudulent or deceitful to issue an order to cease and desist the use of such means or substantially similar means in the diagnosis or treatment of cancer which shall be binding upon the individual, group, body, association or organization using said means of diagnosis or treatment.

(f) To apply to the Superior Court of any county for the issuance of appropriate order restraining the use of said means of diagnosis or treatment of cancer.

ACTION: Adopted by House.

* * *

C.P.S. SPONSORSHIP OF DOCTORS' NEWS CONFERENCE

Resolution No. 61.
Author: John Schaupp.
Representing: San Francisco Medical Society.

WHEREAS, Members of the California Medical Association are desirous of giving the public an opportunity to see and hear accurate information concerning their health; and

WHEREAS, The TV program Doctors' News Conference, presented in the Bay Area through the cooperation of the San Francisco, San Mateo, Santa Clara, Marin and Alameda-Contra Costa Medical Societies, does disseminate beneficial and sound medical information; and

WHEREAS, California Physicians' Service will sponsor this program on Tuesday evenings at 8:00 p.m. for the next six months; and

WHEREAS, We have not been hesitant to criticize some actions of California Physicians' Service; now, therefore, be it

Resolved, That the California Medical Association go on record as commending California Physicians' Service for their cooperation with the physicians of California and their forward-looking attitude in sponsoring this public service program.

ACTION: Adopted by House.

FEES FOR PREPARATION OF INSURANCE FORMS

Resolution No. 62.
Author: James Thompson.
Representing: San Francisco Medical Society.

WHEREAS, The successful operation of both private and governmental health insurance plans requires the use of certain forms filled out and submitted to the respective carriers by physicians, and

WHEREAS, The preparation of these forms constitutes a medical service which occupies a significantly large and ever-increasing portion of the time of the physician and his office staff; and

WHEREAS, It is no longer economically possible to offer this medical service gratuitously; now, therefore, be it

Resolved, That the Commission on Medical Services of the California Medical Association be directed to include a section on fees for preparation of insurance forms in the Relative Value Fee Study and take whatever steps may be necessary to include fees for form preparation in the fee schedules of all insurance plans approved by the California Medical Association.

ACTION: Adopted by House.

* * *

NURSING PRACTICE ACT

Resolution No. 67.
Author: Edward Liston.
Representing: Santa Clara County Medical Society.

WHEREAS, Section 2718 of the Nursing Practice Act provides that the Board of Nurse Examiners shall appoint from a list of names presented by the C.M.A. the representatives who shall serve on the Advisory Council to the Board of Nurse Examiners; and

WHEREAS, This procedure enables the Board of Nurse Examiners to obtain only the advice it chooses to obtain; now, therefore, be it

Resolved, That the Legislative Committee of the California Medical Association take steps to amend the Nursing Practice Act to enable the medical profession to have a more effective voice in nursing education.

ACTION: Adopted by House.

* * *

DOCTOR-HOSPITAL RELATIONS

Resolution No. 71.
Author: Grant Ellis.
Representing: District 9 Delegation.

WHEREAS, The practice of radiology is a medical service and not a hospital service; and

WHEREAS, California law prohibits the practice of medicine by a corporation; and

WHEREAS, There exists at present an embarrassing inequity between radiologists who practice in hospitals under contracts of various kinds and radiologists who are in private practice of radiology; and

WHEREAS, The implementation of this resolution need not adversely affect revenue hospitals derive from the operation of x-ray departments; now, therefore, be it

Resolved, That the California Medical Association declare to all California hospitals having x-ray departments that radiologists who are members of the California Medical Association and who practice in hospitals shall practice as free and independent physicians with complete authority to conduct and supervise the operation of the x-ray department, and that the radiologist shall formulate all fees and if he desires shall submit and collect bills in his own name, and that there shall be no employer-employee relationship between hospitals and radiologists, and that radiologists' services be paid as medical services.

ACTION: Adopted by House.

RESOLUTIONS REFERRED TO COUNCIL

The following resolutions, by vote of the House of Delegates, were referred to the Council for further study and such action as the Council might wish to take. The Council will report back to the House of Delegates its decisions on the subjects involved.

* * *

INDIGENT CARE

Resolution No. 18.
Author: Eleventh C.M.A. District.
Representing: Eleventh C.M.A. District.

WHEREAS, Recent acts of the Congress of the United States and the Legislature of the State of California have brought on the people of the Nation and of this State an initial form of government controlled medicine which is bureaucratic, arbitrary and subject to governmental whim and mismanagement; and

WHEREAS, This is contrary to the best interests of the health of the elderly people of this State; and

WHEREAS, Politicians have further put in provisions which give nonindigent and nondeserving persons access to these medical services; and

WHEREAS, This is a further imposition on the taxpayers, statewide and nationwide; and

WHEREAS, These medical acts do indeed represent a relative failure of our public relations and legislative programs with the Legislature, Congress and the people at large; and

WHEREAS, Even more and greater abuses and inequities are apparent in the proposed Forand bill pending before the United States Congress; now, therefore, be it

Resolved: 1. That the House of Delegates instruct the Council of the California Medical Association to set up a specially designated committee to study, anticipate, educate, and, in the very best interests of the people of this State, prepare for similar legislation that will surely be presented in the not too distant future to our state lawmakers;

2. That this committee be empowered to engage the services of public relations experts and any others whose special aptitudes and qualifications might make their services of value;

3. That this House authorize this committee, subject to approval by the Council, to spend any reasonable sums to further this public relations and legislative program;

4. That should it become necessary, the Council be authorized to levy any assessments necessary to make this program successful; and be it further

Resolved, That this House of Delegates instruct the delegates to the American Medical Association to present resolutions similar to this in interest and purpose, at the coming session of the American Medical Association in San Francisco.

ACTION: Referred to Council.

(Comment by Reference Committee No. 3: "This resolution contains a number of subjects, many of which are already in Council. Some of the subjects have already been disposed of by other resolutions . . . refer to the Council for further consideration.")

* * *

ESTABLISHMENT OF BETTER COMMUNICATIONS

Resolution No. 23.

Author: Charles D. Armstrong.

Representing and endorsed by San Mateo County Medical Society.

WHEREAS, There seems to be some dissatisfaction regarding the role of the California Medical Association Council in carrying out the wishes of California Medical Association members; now, therefore, be it

Resolved, That the California Medical Association appoint a properly constituted committee to accomplish the following functions:

1. Critically investigate the present system of representation in the California Medical Association and establish the validity of any complaints.

2. In the event valid deficiencies exist, recommend constitutional changes to correct them.

3. Suggest constitutional changes that clearly delineate the exact responsibility of the Council to act for the California Medical Association.

4. Consider use of opinion surveys on a county and state level, and, if appropriate recommend a mechanism to accomplish this.

5. Consider the institution of a system of monthly reports to the California Medical Association Council from constituent medical societies as a means of keeping the California Medical Association Council continuously posted on the views of the California Medical Association members.

6. Consider the institution of a system of monthly reports from the California Medical Association Council to constituent medical societies relative to Council activities and in particular, their proposed actions to keep the membership continually informed.

7. Report back to the House of Delegates, for approval, any other workable plan that the committee may devise to improve communications within the California Medical Association.

ACTION: Referred to Council.

(Comment by Reference Committee No. 3B: "Communications in an organization approximating 16,000 physicians, many of whom find little time for political or economic considerations due to their great interest in the scientific aspects of the practice of medicine, are always very cumbersome. The C.M.A. Council, the various committees, both state and local, the county medical societies, and even hospital staff organizations have struggled with this problem which apparently continues to mount. Any suggestion which might help to relieve this situation should certainly be considered. Although this resolution contains a variety of suggestions, some of which might well be difficult to implement, your committee is of the opinion that these suggestions should be forwarded to the Council of the C.M.A.")

* * *

STUDY COMMITTEE—IMPACT OF SOCIALISM

Resolution No. 42.

Author: Peter Blong.

Representing: Los Angeles County Medical Association.

WHEREAS, Bureaucratic socialism has been on the march; and

WHEREAS, Medicine is now suffering from the same; now, therefore, be it

Resolved, That the California Medical Association implement a committee to study the impact of socialism on the practice of medicine, and to offer means of relief from the same.

ACTION: Referred to Council.

(Comment by Reference Committee No. 3: "The committee feels that the resolution in implementing another committee will duplicate the work of an established committee.")

* * *

C.M.A. USE OF COUNTY SOCIETIES' PERSONNEL

Resolution No. 48.
Author: Anthony S. Felsovanyi.
Representing: Santa Clara County Medical Society.

WHEREAS, There is an evident and increasing need for experienced personnel to serve and assist the members of the various Commissions and Committees of C.M.A. in the pursuance of their objectives and obligations; and

WHEREAS, The need for such services and assistance is most often for part-time personnel with specific interests or experience rather than full-time personnel; and

WHEREAS, There are now 14 experienced and qualified full-time executive secretaries employed by component societies of the C.M.A., and 11 other persons serving 10 other societies in various capacities; now, therefore, be it

Resolved, That the House of Delegates encourage the C.M.A. Commissions to utilize the services of such persons and that the House of Delegates recommend that the Council of C.M.A. approve the use and part-time employment of such persons by C.M.A. Commissions and Committees; and be it further

Resolved, That reimbursement or compensation for such services be made to the respective county medical society or directly to the person so employed, on a basis that is mutually agreeable to the county society-employer of the person and the C.M.A.

ACTION: Referred to Council.

(Comment by Reference Committee No. 3B: "Mr. John Hunton called attention of the committee to the fact that the county executive secretaries meet just prior to each C.M.A. Council meeting and are invited to be present at Council meetings at C.M.A. expense. This resolution suggests that the C.M.A. might gain much by use of the special knowledge and particular talents of this unique group. Details for the implementation of this plan might make it cumbersome in its execution.")

* * *

SPECIAL DIVISION OF THE A.M.A.

Resolution No. 63.
Author: A. Justin Williams.
Representing: San Francisco Medical Society.

WHEREAS, There continues to be increasing third party intervention, governmental and otherwise, between physician and patient to the detriment of good medical practice; and

WHEREAS, Third party intervention inevitably results in unnecessary and often arbitrary restrictions of medical practice and increased costs; now, therefore, be it

Resolved, That an entirely new special division of the American Medical Association be established and staffed with skilled, highly trained individuals responsible only to the A.M.A. Board of Trustees, and that the functions of this division should include

(a) To plan and execute a long range program of preserving the present system of medical practice and the rights of the individual physician to practice medicine in the manner of his choice.

(b) The formulation of further plans to meet the medical needs of the American people under the voluntary free enterprise system.

(c) To offer positive advice and assistance to state and local societies as to courses of action to follow as specific threats to voluntary medical care arise in their areas; and, be it further

Resolved, That the C.M.A. delegates to the A.M.A. introduce a similar resolution to the A.M.A. House of Delegates at the forthcoming meeting.

ACTION: Referred to Council.

(Comment by Reference Committee No. 3: "Because the content of this resolution involves the A.M.A. Board of Trustees, it is felt advisable that it be referred to the Council for further study and action.")

REFERRED TO COMMITTEE

One resolution, No. 60, was referred by the House of Delegates to the Committee on Claims Forms, a subcommittee of the Commission on Medical Services. This resolution reads as follows:

INSURANCE CLAIM PROCESSING

Resolution No. 60.
Author: F. J. Novak.
Representing: San Mateo County.

WHEREAS, Insurance claim processing in doctors' offices is an increasingly heavy burden; and

WHEREAS, Present claim processing is done by antiquated hand methods; therefore, be it

Resolved, That the California Medical Association appoint a committee to work out the possibility of having the many insurance companies pool their claims departments and form a central clearing house for claim processing. Such a clearing house should utilize the available electronic machines for less costly and speedier claim processing.

CONSTITUTIONAL AMENDMENTS ADOPTED

The Constitution of the California Medical Association was amended at the 1958 Annual Session when the House of Delegates by the required two-thirds vote adopted these amendments which had been lying on the table for one year and had been published in two separate issues of the official journal, as required by the Constitution.

As originally introduced, an additional amendment to apply to Section 14 of Article III, Part B, of the Constitution was included with the three amendments shown here. The House of Delegates voted against the proposed amendment to Section 14 and, instead, approved a By-Law amendment to provide a method of election of District Councilors.

As adopted by the House of Delegates, the amendments to the Constitution will make these sections read as follows:

AMENDMENTS

ARTICLE III

Part B—Council

Section 9—Composition

The Council shall consist of:

(a) Each Councilor District, as specified in this Constitution, shall be entitled to one Councilor for each 1,000 members, according to its membership as of the first day of November of the preceding year; provided that each Councilor District shall be entitled to a minimum of one Councilor.

(b) The President, President-Elect, Speaker and Vice-Speaker.

In addition, the Secretary-Treasurer, and Editor ex-officio, without the right to vote.

(c) District Councilors shall be elected from the Councilor Districts.

(d) Elected Councilors from any one District shall not, at any time, exceed forty per cent (40 per cent) of the total Council membership.

Section 10—Councilor Districts

There are ten districts as follows:

District Number One, comprising San Diego County.

District Number Two, comprising Imperial, Orange, Riverside, San Bernardino, Mono and Inyo Counties.

District Number Three, comprising the County of Los Angeles.

District Number Four, comprising Ventura, Santa Barbara and San Luis Obispo Counties.

District Number Five, comprising Kern, Kings, Tulare, Fresno, Madera, Mariposa, Merced, Stanislaus, San Joaquin, Calaveras and Tuolumne Counties.

District Number Six, comprising Monterey, San Benito, Santa Cruz, Santa Clara and San Mateo Counties.

District Number Seven, comprising San Francisco County.

District Number Eight, comprising Alameda County and Contra Costa County.

District Number Nine, comprising Marin, Solano, Napa, Sonoma, Lake, Mendocino, Humboldt and Del Norte Counties.

District Number Ten, comprising Sacramento, Amador, Alpine, Eldorado, Placer, Nevada, Sierra, Yuba, Sutter, Yolo, Colusa, Glenn, Butte, Plumas, Tehama, Trinity, Shasta, Lassen, Modoc and Siskiyou Counties.

Section 11—Election of Councilors

District Councilors shall be elected by vote of the delegates from each district in the manner and at the time specified in the by-laws; provided, however, that at the first meeting of the House of Delegates after a District Councilor has been selected, his name shall be submitted to the House by the delegates from the district, and (1) if there is no challenge by any delegate then the Speaker shall declare his election completed, and (2) if any delegate shall challenge the election on any ground, including fitness of the nominee of the district to serve as a District Councilor, the questions presented by the challenge shall be submitted to a Qualifications Committee consisting of the President, President-Elect and one delegate, appointed by the Speaker, from the Councilor District involved. The Qualifications Committee shall consider all grounds upon which the nominee is challenged and report back to the House. If the committee reports in favor of confirming the nominee's election, the Speaker shall declare him elected. If the committee reports against confirming the nominee's election, a three-fourths affirmative vote shall be necessary to sustain the report of the committee, in which event the nominee shall be ineligible to serve as the District Councilor and the delegates from the district shall immediately proceed to the selection of another nominee for the vacant office. If an adverse report of the Qualifications Committee is not sustained then the nominee shall be declared elected by the Speaker.

BY-LAW AMENDMENTS ADOPTED

The House of Delegates adopted a series of By-Law amendments at its 1958 Annual Session. Under the requirements of the By-Laws, all amendments must lie on the table for 24 hours before being acted upon. The amendments shown here were introduced at the first session of the House of Delegates on April 27, were referred to Reference Committee No. 4 and reported back, for vote, at the April 30 session.

By-Law amendments approved are shown here in the manner in which they were introduced and adopted. This presentation does not show the resultant wording of each section affected but defines the wording or paragraph in which a change was made.

Where parentheses and italics are used in the amendments shown, the words in parentheses have been deleted from the former By-Law section and the words in italics have been added.

Proposed amendments that were not adopted are not recorded in this abridged report.

* * *

REDUCTION OF DUES

By-Law Amendment No. 2.
Author: Donald D. Lum.
Representing: The Council.

Resolved, That Chapter X, Section 3, of the By-Laws be amended so that paragraph (a) of that section be amended to delete the words shown here in parentheses and to add the words shown here in italics, so that this paragraph shall read as follows:

(a) Those active members who have been in the practice of medicine for less than (one) *three* years on the first day of the calendar year for which such dues were payable, may be reduced to (one-fourth regular dues) *such sum as the Council may recommend and the House of Delegates approve.*

And be it further

Resolved, That paragraph (b) and paragraph (c) of Chapter X, Section 3, of the By-Laws be deleted. And be it further

Resolved, That paragraph (d) of Chapter X, Section 3, be amended by deleting all language starting with the last syllable of the seventh line, relating to the dues of members who have reached the age of 70 years, and substituting therefor the following ". . . excused from the payment of annual dues."

* * *

AUDITING COMMITTEE

By-Law Amendment No. 3.
Author: Donald D. Lum.
Representing: The Council.

Resolved, That the name of the Auditing Committee be changed to Finance Committee, and to accomplish that change, that Chapter VI, Section 7, of the By-Laws be reworded so that the term "Finance Committee" is substituted for the term "Auditing Committee" in the title and the text of the section; and be it further

Resolved, That Chapter X, Section 1, of the By-Laws be deleted in its present form and the following substituted:

CHAPTER X—FUNDS, PROPERTY, BUDGET AND ASSESSMENTS

Section 1—Preparation of Budget

The Finance Committee shall prepare each year a budget of anticipated income and expenditures, to apply to the succeeding fiscal year of the Association. The budget shall be prepared in consultation and with the cooperation of officers, commission and committee chairmen, administrative employees and others with a knowledge of the needs of the Association.

Prior to the Annual Session in each year the Finance Committee shall present the proposed budget to the Council for its approval, and the budget as approved by the Council shall be submitted by it to the House of Delegates.

And be it further

Resolved, That Chapter X, Section 6, of the By-Laws be amended as to the second paragraph of that section so that the words shown below in parentheses shall be deleted and the words shown in italics be inserted, so that the paragraph shall read as follows:

The (Auditing) *Finance* Committee shall inspect all bills and no demands or claims against the Association shall be paid and no funds or moneys of the Association be withdrawn from any depositary thereof except upon (written) approval of (a majority of all) the members of the (Auditing) *Finance* Committee on check or draft signed by (any two) persons authorized by the Council, providing all such authorized signers are under bond.

* * *

MEMBERSHIP COUNT

By-Law Amendment No. 4.
Author: Donald D. Lum.
Representing: The Council.

Resolved, That Chapter IX, Section 2, Subsection (h), of the By-Laws be amended by deleting the words shown below in parentheses and inserting the words shown below in italics, so that the section shall read as follows:

(h) Register of Component Society, Their Mem-

bers and Officers. He shall keep a register of all component societies, their respective officers, and of all members of the Association, with their addresses. He shall print in the *December or* January (or February) issue of the official journal the number of active members of each component society as of (November) *September* 1st of the preceding year.

* * *

CHAIRMAN OF THE COUNCIL

By-Law Amendment No. 5.
Author: Donald D. Lum.
Representing: The Council.

Resolved, That Chapter IX, Section 3, of the By-Laws be amended by adding the words shown below in italics, so that the section shall read as follows:

Section 3—Duties and Powers of the Chairman of the Council

The Chairman of the Council shall preside at all meetings of the Council. He shall *be authorized to* sign all contracts and agreements, conveyances, transfers and other instruments (other than advertising contracts) to which the Association is a party, the execution of which has been authorized by the Council or the House of Delegates. He shall *be authorized to* sign all checks or drafts. . . .

Balance of the section to remain in present language.

* * *

JUDICIAL COMMISSION

By-Law Amendment No. 6.
Author: Donald D. Lum.
Representing: The Council.

Resolved, That Chapter III, Section 1, Subsection 6, of the By-Laws of the California Medical Association be amended as to the second paragraph of that section, so that the words shown in parentheses below shall be deleted and the words shown in italics shall be added:

(Either the Council or the Executive Committee) *The Judicial Commission* of the California Medical Association, whenever it shall come to (the) *its* attention (of either) that a disciplinary proceeding is pending before any component society, may . . .

Balance of the section to remain in present language.

And be it further

Resolved, That Chapter III, Section 1, Subsection 10, of the By-Laws be amended as to both paragraphs of that section by deleting the word "Council" and substituting therefore the words "Judicial Commission."

SECRETARY-TREASURER

By-Law Amendment No. 7.
Author: Donald D. Lum.
Representing: The Council.

Resolved, That Chapter IX, Section 2, of the By-Laws be amended to delete the word "-Treasurer" from the title of the section, so that the title refers to "Secretary" as one of the named persons.

And be it further

Resolved, That Chapter IX, Section 2(a), of the By-Laws be amended to delete the words shown here in parentheses, so that the subsection shall read:

(a) Minutes. The Secretary (-Treasurer, [who may also be referred to as Secretary or Treasurer]) shall attend the general meetings of the Association, the meetings of the House of Delegates *and* of the Council, (and of the Executive Committee) and shall keep minutes of their respective proceedings in separate record books.

And be it further

Resolved, That the title "Secretary-Treasurer" be amended to read "Secretary" in Chapter IX, Section 2, Subsections (a), (d), (e), (o), and (p); in Chapter II, Sections 2(a) and 2(b); in Chapter VI, Section 13; in Chapter VII, Section 10; in Chapter X, Section 6 and 7, and in any other chapter or section in which this title is now used as "Secretary-Treasurer."

* * *

EXECUTIVE COMMITTEE

By-Law Amendment No. 8.
Author: Donald D. Lum.
Representing: The Council.

Resolved, That the Executive Committee be abolished and that a new committee to be known as the Advisory Committee for Emergency Action be established in its place; that, to accomplish this, Chapter VI, Section 6, of the By-Laws is hereby deleted in its entirety; and be it further

Resolved, That a new Chapter VI, Section 6, of the By-Laws is hereby adopted, to read as follows:

Section 6—Advisory Committee for Emergency Action

The Advisory Committee for Emergency Action shall consist of the President, the President-Elect, the Chairman of the Council and the Speaker of the House of Delegates.

It shall have no policy-making powers and shall function only under the direction of the Council. Its actions shall be subject to review and approval by the Council and it shall act only on matters requiring urgent decision while the Council is not in session.

And be it further

Resolved, That Chapter III, Section 1, Subsection 6, of the By-Laws be amended by deleting the phrase "or the Executive Committee" from the second paragraph of the section.

And be it further

Resolved, That the phrase "Executive Committee" or any reference to it or its chairman be deleted from Chapter VI, Section 10 and 15 and from Chapter IX, Section 2, Subsections (a), (i) and (r).

* * *

AMENDMENT TO BY-LAWS

By-Law Amendment No. 13.
Author: S. J. McClendon.
Representing: Constitution Study Committee.

Resolved, That Section 6 of Chapter VIII of the By-Laws of the California Medical Association be amended by changing the title of said section to read as follows: "Election of District Councilors in Districts Having One Councilor"; and be it further

Resolved, That a new Section 6.5 be added to Chapter VIII of said By-Laws to read as follows:

Section 6.5—Election of District Councilors in Districts Having More Than One Councilor

Immediately on the adoption of this section, and in succeeding years at least twenty-four hours prior to the second meeting at each annual session of the House of Delegates, the Delegates from those Districts in which more than one Councilor vacancy exists or is about to occur shall separately meet and in each such District the Delegates shall elect a chairman and a secretary.

At the first such caucus in each such District, the aggregate number of vacancies existing shall be divided into Offices No. 1, No. 2 et seq, with Offices Nos. 1, 4 and succeeding multiples of three carrying an initial term of one year and then thereafter terms of three years; with Offices Nos. 2, 5 and succeeding multiples of three carrying initial terms of two years and thereafter terms of three years; and with offices Nos. 3, 6 and succeeding multiples of three carrying initial terms of three years and thereafter terms of three years.

Nominations shall then be received for each individually numbered office in which a vacancy exists, and in each instance where there is more than one nomination, election shall be by secret ballot and majority vote of the Delegates present and voting. The chairman of the District delegation shall then report to the House of Delegates the results of the election, and when such report is made, the members elected shall thereupon assume office as District Councilors, subject to the provisions of the Constitution and By-Laws.

At the second and succeeding caucuses the Delegates in each such District shall by nomination, secret ballot and majority vote of the Delegates present and voting, elect District Councilors for each individual numbered District Councilor office from such District for which a vacancy is about to occur, and the chairman of the District delegation shall report at the second meeting of the House of Delegates the results of the election, and when such report is made, the member or members elected shall assume office as a District Councilor or District Councilors, subject to the provisions of the Constitution and By-Laws.

The time and place of the caucus of each District delegation shall, in the absence of unanimous written consent of the Delegates of the District fixing time and place, be fixed by the Speaker and announced at the first meeting of the House of Delegates at each annual session; except that on the adoption of this section, the Speaker shall immediately announce a time and place for the immediate caucus of each District that is at the time of said adoption, entitled to more than one District Councilor.

In the event there are more than two nominees at any District caucus for any of the individual numbered offices of District Councilor in said District and none of such nominees receives a majority of the votes cast on the first ballot, the nominee receiving the smallest number of votes on such ballot shall be eliminated and a second ballot shall be taken on the remaining nominees, such process to continue until one such nominee shall receive a majority of the votes cast.

* * *

JUDICIAL COMMISSION

By-Law Amendment No. 15.
Author: Donald A. Charnock.
Representing: Judicial Commission.

The Judicial Commission requests that Chapter III, Section 3 (paragraph 4) be changed to read:

"In every case of an appeal the Judicial Commission of this Association, through a committee thereof, prior to any hearing being held upon appeal may exert all proper efforts at conciliation and compromise."

* * *

AMENDMENT TO BY-LAWS—JUDICIAL COMMISSION

By-Law Amendment No. 16.
Author: John Blum.
Representing: District 9 Delegation.

WHEREAS, Chapter 3, Section 1, Paragraph 9, of the By-Laws of the California Medical Association

relative to disciplinary procedures limits the discretion of the Judicial Commission of the California Medical Association in providing that no member may be suspended for a period longer than one year; and

WHEREAS, When a member of the C.M.A. is suspended under this paragraph it is mandatory that he be reinstated into membership after the period of one year, regardless of his behavior during that period of suspension; now, therefore, be it

Resolved, That Chapter 3, Section 1, Paragraph 9, of the By-Laws of the California Medical Association be amended to delete the words "provided that in no case shall a member be suspended for a period greater than one year"; and be it further

Resolved, That this paragraph be further amended to add the words—"The Judicial Commission, at the end of the suspended member's period of suspension, may consider the quality of his behavior during his suspension in determining whether he shall be readmitted to the Society."

BY-LAW AMENDMENT OFFERED

One By-Law amendment was offered at the April session of the House of Delegates by Reference Committee No. 4, the committee to consider proposed amendments to the Constitution and By-Laws. Since all proposed amendments to the By-Laws are required to lie on the table for 24 hours before being acted upon, this amendment must await the next regular session of the House of Delegates before it can be voted upon. The proposed amendment to the By-Laws reads as follows:

AMENDMENT TO BY-LAWS

By-Law Amendment No. 1.
Author: J. B. Price.
Representing: Reference Committee No. 4.

Resolved, That Chapter VII, Section 1, of the By-Laws be amended as follows:

First, delete subsection (b) and insert

"(b) *Commission on Public Health,* responsible for the activities of and through which the following standing committees shall report:

1. Committee on Rural and Community Health,
2. Committee on School Health,
3. Committee on Mental Health,
4. Committee on Industrial Health.

"(c) *Commission on Public Agencies,* responsible for the activities of and through which the following standing committees shall report:

1. Committee on Military Affairs and Civil Defense,
2. Committee on State Medical Services,
3. Committee on Veterans Affairs,
4. Committee on Other Professions,
5. Committee on Blood Banks,
6. Committee on Allied Health Agencies.

Secondly, re-letter the following subsections from (c) to (d) through (1).

Except as herein amended, said Chapter VII, Section 1, shall remain unchanged.

CONSTITUTIONAL AMENDMENTS OFFERED

Four proposed amendments to the Constitution of the California Medical Association were presented at the 1958 House of Delegates. Under the terms of the Constitution, these proposed amendments must lie on the table for one year, or until the next regular session of the House of Delegates. Meanwhile, they must be published at least twice, in separate issues of the official journal.

All members of the Association, and especially the members of the House of Delegates, will thus have the opportunity to review these proposals during the coming year. They will be presented to the 1959 House of Delegates for vote, on which a two-thirds affirmative vote of those Delegates present and voting is required for passage.

* * *

SECRETARY-(TREASURER)

Constitutional Amendment No. 1.
Author: Donald D. Lum.
Representing: The Council.

Resolved, That Article VI, Section 1, of the Constitution be amended by deleting the term "-Treasurer" from the present term "Secretary-Treasurer" so that the named officer shall be known as "Secretary."

* * *

REPRESENTATION IN HOUSE OF DELEGATES

Constitutional Amendment No. 2.
Author: Sam J. McClendon.
Representing: Constitution Study Committee.

Resolved, That Article III, Part A, Section 2, of the Constitution of the California Medical Association be amended by deleting the words shown in parentheses below, so that the section shall read as follows:

Section 2—Representation

As the By-Laws shall provide, each component society shall be entitled to proportionate representation in the House of Delegates (but with a minimum of two delegates).

* * *

REPRESENTATION ON THE COUNCIL

Constitutional Amendment No. 3.
Author: Sam J. McClendon.
Representing: Constitution Study Committee.

Resolved, That Article III, Part B, Section 9, of the Constitution be amended in subparagraph (a) by deleting the words shown in parentheses below and adding the words shown below in italics, so that subparagraph (a) shall read as follows:

(a) Each Councilor District, as specified in this Constitution, shall be entitled to one Councilor for each 1,000 *active* members, *or major fraction thereof,* according to its membership as of the first day of (November) *September* of the preceding year; provided that each Councilor District shall be entitled to a minimum of one Councilor.

* * *

DELEGATES FROM SECTIONS

Constitutional Amendment No. 4.
Author: A. B. Sirbu.
Representing: San Francisco Medical Society.

WHEREAS, The scientific sections constitute an important part of the structure of the C.M.A.; and

WHEREAS, The sections are not represented in the legislative body of the C.M.A., the House of Delegates; and

WHEREAS, The sections of the A.M.A. have for many years been represented in its House of Delegates; and

WHEREAS, Each section of the C.M.A. has much to contribute toward policy making, both in the scientific and the economic phases of medicine; now, therefore, be it

Resolved, That each section of the C.M.A. be entitled to send one delegate with full voting rights to the House of Delegates of the C.M.A.; and be it further

Resolved, That the C.M.A. Constitution be amended to allow for such representation as follows: Article III, Section 1 amended by the addition of (e) Delegates elected by each scientific section as listed in Chapter IV, Section 1-a of the By-Laws.

* * *

CONSIDERATION OF CONSTITUTIONAL AMENDMENTS

Constitutional Amendment No. 5
Author: W. S. Lawrence.
Representing: Butte-Glenn Medical Society.

WHEREAS, Any amendment to the Constitution should be for the greatest good of the Association; and

WHEREAS, The most recent amendment to the Constitution which eliminates the Councilors-at-Large was passed without prior hearings in the appropriate reference committee during any regular session of the Association; and

WHEREAS, This action has denied interested delegates the opportunity to meet, exchange views, discuss the ramifications and evaluate the appropriateness of the Amendment to meet its purpose; and

WHEREAS, The proponents of the amendment would be the last to feel the necessity to press such an action through the House of Delegates without adequate consideration; now, therefore, without prejudice to the previous amendment, be it

Resolved: That Article VIII, Section 3, Paragraph 2 of the Constitution be amended by addition of the following:

"Further, such proposed amendment or amendments shall be referred to the appropriate Reference Committee who shall hold hearings on the proposed amendment or amendments during the course of its regular business while the Association is in convention. If the proposal or proposals are introduced during the first session of the House, hearings shall be held at both the current and the next regular meeting. If the proposal or proposals are introduced during the second session, hearings shall be held at the next meeting, and in either event, prior to submission to the House of Delegates for vote.

ELECTION RESULTS

Elections held by the House of Delegates in its final session April 30 saw Doctor T. Eric Reynolds of Oakland elected as President-Elect of the California Medical Association for 1958-1959.

Doctor James C. Doyle was reelected Speaker of the House of Delegates and Doctor Ivan C. Heron was chosen as Vice-Speaker.

In the election of Councilors, who are selected by their own District Delegations, Doctors James C. MacLaggan of San Diego and Warren L. Bostick of San Rafael were chosen by their districts to serve additional three-year terms as Councilors and Doctor Burt L. Davis of Palo Alto was named by his district for a new three-year term.

Los Angeles County, entitled to six District Councilors under the terms of the revised Constitution,

chose Doctors Malcolm Todd of Long Beach and Arthur A. Kirchner of Los Angeles to serve one-year terms, Doctors Paul D. Foster of Los Angeles and Joseph P. O'Connor of Pasadena for two-year terms and Doctors J. Norman O'Neill of Los Angeles and Gerald W. Shaw of Santa Monica for three-year terms.

In selecting Delegates to the A.M.A. the House of Delegates reelected Doctors Leopold H. Fraser, E. Vincent Askey, Dwight L. Wilbur, Donald Cass, J. Lafe Ludwig, R. Stanley Kneeshaw, C. J. Attwood and James E. Feldmayer for additional two-year terms. The House also elected Doctor Donald A. Charnock a Delegate, to fill the new office created by the Association's membership growth.

As Alternate Delegates, incumbents Hartzell H. Ray, Francis J. Cox, J. Norman O'Neill, H. M. Van Dyke, Burt Davis, Arlo A. Morrison were all reelected for two-year terms. Doctor Ralph C. Teall was chosen as Alternate to succeed Edward C. Rosenow, Jr., and James C. Doyle was picked to fill the unexpired term of Donald A. Charnock for the balance of 1958 and for an additional two-year term. As the new Alternate the House picked Doctor Carl M. Hadley of San Bernardino.

Upon nomination by the Council, the House of Delegates reelected Doctors Dave F. Dozier and Arlo A. Morrison, Mr. Thomas Hadfield and Rt. Rev. Msgr. Thomas J. O'Dwyer as members of the Board of Trustees of California Physicians' Service. Also nominated by the Council and approved by the House was Doctor Paul Hoagland of Pasadena, to fill an unexpired term of office.

In accordance with the By-Laws of C.P.S. the Council also selected from its own membership Doctors Ivan C. Heron, Gerald W. Shaw and Burt L. Davis as Trustees of C.P.S. for the coming year.

* * *

In its own elections and appointments, the Council at an organization meeting held April 30 reelected Doctor Donald D. Lum as Chairman of the Council and chose Doctor Samuel R. Sherman as Vice-Chairman. Doctor Albert C. Daniels was reappointed Secretary and Doctor Dwight L. Wilbur was renamed Editor. Mr. John Hunton was reappointed Executive Secretary and the firm of Peart, Baraty & Hassard was reappointed as legal counsel.

In Memoriam

ATLAS, LAWRENCE N. Died May 22, 1958, aged 52. Graduate of Western Reserve University School of Medicine, Cleveland, Ohio, 1930. Licensed in California in 1952. Doctor Atlas was a member of the Los Angeles County Medical Association.

✤

BERGMAN, GEORGE CLYDE. Died December 21, 1957, aged 60. Graduate of the College of Medical Evangelists, Loma Linda-Los Angeles, 1924. Licensed in California in 1924. Doctor Bergman was a member of the Los Angeles County Medical Association.

✤

CHADWICK, GLENN WILLIAM. Died March 12, 1958, aged 34. Graduate of the College of Medical Evangelists, Loma Linda-Los Angeles, 1951. Licensed in California in 1951. Doctor Chadwick was a member of the Los Angeles County Medical Association.

✤

GUINAN, EDWARD ROBERT. Died in Palo Alto, May 26, 1958, aged 69, of congestive heart failure, pneumonia, and bronchogenic carcinoma. Graduate of Cooper Medical College, San Francisco, 1911. Licensed in California in 1911. Doctor Guinan was a retired member of the Alameda-Contra Costa Medical Association and the California Medical Association, and an associate member of the American Medical Association.

✤

HERMAN, BORIS S. Died in San Francisco, May 8, 1958, aged 68. Graduate of the College of Physicians and Surgeons of San Francisco, 1919. Licensed in California in 1919. Doctor Herman was a member of the San Francisco Medical Society.

✤

KERR, WILLIAM J., JR. Died in Marin County, May 27, 1958, aged 39. Graduate of Harvard Medical School, Boston, Massachusetts, 1944. Licensed in California in 1946. Doctor Kerr was a member of the Marin County Medical Society.

✤

PARKER, CARL HORACE. Died in Pasadena, May 15, 1958, aged 75. Graduate of Rush Medical College, Chicago, Illinois, 1909. Licensed in California in 1909. Doctor Parker was a retired member of the Los Angeles County Medical Association and the California Medical Association, and an associate member of the American Medical Association.

✤

SCHEPPLER, GEORGE CAROL. Died April 18, 1958, aged 41, of injuries received in an automobile collision. Graduate of the College of Medical Evangelists, Loma Linda-Los Angeles, 1945. Licensed in California in 1945. Doctor Scheppler was a member of the Humboldt County Medical Society.

✤

SCHWING, HAROLD EDWARD. Died in Sacramento, May 18, 1958, aged 64. Graduate of the University of Buffalo School of Medicine, New York, 1923. Licensed in California in 1930. Doctor Schwing was a member of the Sacramento Society for Medical Improvement.

Annual Meeting

Civic Auditorium

SAN FRANCISCO

February 22 to 25, 1959

Papers for Presentation

If you have a paper that you would like to have considered for presentation, it should be submitted *to the appropriate section secretary* (see list on this page) no later than September 1, 1958.

Scientific Exhibits

Space is available for scientific exhibits. If you would like to present an exhibit, please write immediately to the office of the California Medical Association, 450 Sutter Street, San Francisco 8, for application forms. To be given consideration by the Committee on Scientific Work, the forms, completely filled out, must be in the office of the California Medical Association no later than September 1, 1958. (No exhibit shown in 1958, and no individual who had an exhibit at the 1958 session, will be eligible until 1960.)

Medical Motion Pictures

There will be facilities available for motion pictures. If you would like to exhibit a film, send your application to Dr. Paul D. Foster, 1930 Wilshire Boulevard, Los Angeles 57. The deadline is October 15, 1958.

SCIENTIFIC PAPERS
SCIENTIFIC EXHIBITS
MEDICAL MOTION PICTURES
PLANNING MAKES PERFECT
AN EARLY START HELPS

SECRETARIES OF SCIENTIFIC SECTIONS

ALLERGY . . . . . **George F. Harsh**
2001 Fourth Avenue, San Diego 1

ANESTHESIOLOGY . . . . . **Charles D. Anderson**
439 30th Street, Oakland 9

DERMATOLOGY AND SYPHILOLOGY . **Herbert L. Joseph**
607 Carolina Street, Vallejo

EAR, NOSE AND THROAT . . . . **Ewing Seligman**
9735 Wilshire Boulevard, Beverly Hills

EYE . . . . . **A. Ray Irvine, Jr.**
2010 Wilshire Boulevard, Los Angeles 57

GENERAL PRACTICE . . . . . **James S. Eley**
624 Harris Street, Eureka

GENERAL SURGERY . . . . . **William F. Pollock**
2200 Santa Monica Boulevard, Santa Monica

INDUSTRIAL MEDICINE AND SURGERY . . . . . **Gandolph A. Prisinzano**
4041 H Street, Sacramento 19

INTERNAL MEDICINE . . . . . **Edward Shapiro**
123 North San Vicente Boulevard, Beverly Hills

OBSTETRICS AND GYNECOLOGY . . **Donald R. Nelson**
2439 Ocean Avenue, San Francisco 27

ORTHOPEDICS . . . . . **Howard A. Mendelsohn**
415 North Camden Drive, Beverly Hills

PATHOLOGY AND BACTERIOLOGY . . . **Leo Kaplan**
8720 Beverly Boulevard, Los Angeles 48

PEDIATRICS . . . . . **Gordon L. Richardson**
10711 Riverside Drive, North Hollywood

PHYSICAL MEDICINE . . . . **Carrie E. Chapman**
VA Hospital, 13th and Harrison Streets, Oakland 12

PSYCHIATRY AND NEUROLOGY . . **John D. Moriarty**
7046 Hollywood Boulevard, Hollywood 28

PUBLIC HEALTH . . . . . **Carolyn B. Albrecht**
920 Grand Avenue, San Rafael

RADIOLOGY . . . . . **William H. Graham**
630 East Santa Clara Street, San Jose 12

UROLOGY . . . . . **Earl F. Nation**
112 North Madison Avenue, Pasadena 1

WOMAN'S AUXILIARY
TO THE CALIFORNIA MEDICAL ASSOCIATION

WITH A SHORTER period than usual to achieve our customary objectives before the next annual meeting, which is to be in February next year, it seemed feasible to begin making visits to county auxiliaries in May while some of them were still having meetings before closing their fiscal year. So, the Monday following the annual convention in Los Angeles we took plane for "the north."

Shasta County was the first stop on our itinerary. The meeting in Redding was my first contact with these northern counties. Next stop Tehama, then Yuba, Sutter, Colusa and, after a week-end in San Francisco, Santa Cruz and San Mateo.

In each of the counties I found enthusiasm at top level. In Tehama County at Red Bluff a tight little group of eight members is making its efforts count in that thriving community. The Yuba-Sutter-Colusa auxiliary is carrying on a full program of our objectives. And so it goes: In each county, be the auxiliary large or small in numbers, the groups are contributing their fair share to their individual communities and to the combined efforts of all the counties in the state.

It would amaze some of the county medical society members if they would make it their business to ask these energetic wives of theirs to explain to them the whys and wherefores of their activities.

We think that our support of the medical program as directed by the California Medical Association is vital to the well-being of our world society, and we are ready and willing to help.

These auxiliaries are not just "women's clubs" or "bridge clubs." They devote their collective energies to intelligently planned projects that are important to the improvement of health in their communities. They are creating a public relations atmosphere for the physician—public contact that the physician himself would be unable to accomplish.

They are serving the Medical Association, and the public too, by the "woman's approach" to medical legislation, as it pertains to the efficiency of their ideals.

Both the American Medical Association and the California Medical Association spent a good deal of money recently for expert advice on the improvement of their over-all programs of management, and one of the important suggestions made by the experts (and accepted by the associations) was to form a closer alliance with their auxiliaries. May I humbly suggest, therefore, that on the county level the societies also avail themselves of the opportunity to learn first-hand of the potential embodied in the distaff side of their profession.

We think a simple solution and a gracious gesture of interest would be for each county society to appoint a member of the society to attend at least one general meeting of their auxiliary. He would be pleased with the results.

I wish you could all see the May fifteenth issue of the Los Angeles County Medical Association *Bulletin*—it was devoted to the activities of the local county auxiliary. Articles contributed were written and edited by members—pictures were numerous—beautiful, too.

Articles of appreciation and commendation by Lewis T. Bullock, M.D., president of the Los Angeles County Society; by the editor of the *Bulletin*, William F. Quinn, M.D., and by the Los Angeles County executive director, Edward C. Rosenow, Jr., M.D., were included and the "gals" are ecstatic—not only because of the feat accomplished by their large auxiliary, but because of the recognition on the part of a large county society of the value of the services rendered in its behalf.

We would be delighted if all of our county auxiliaries could achieve the same cooperation from their individual societies—it would give us statewide status and prestige as a reward for our efforts.

May we count on your county society support to this end?

MRS. NEWELL JONES,
President, Woman's Auxiliary to the California Medical Association

NEWS & NOTES

NATIONAL • STATE • COUNTY

ALAMEDA

Dr. Charles E. Smith, dean of the University of California School of Public Health, has been selected as the recipient of the **John J. Sippy Memorial Award,** the highest honor of the Western Section of the American Public Health Association.

The award was bestowed on Dr. Smith in honor of his outstanding accomplishments and contributions in the field of public health as an educator, administrator and research investigator. It was presented at the joint annual meeting in Vancouver, B. C., of the Western Section of the A.P.H.A. and the Canadian Public Health Association.

Dr. Smith was cited for his investigations into the cause and diagnosis of coccidioidomycosis, for his role as dean of the U. C. School of Public Health and for his many contributions to national, state and local health programs.

* * *

The 1958 **Western Industrial Health Conference,** sponsored by the Western Industrial Medical Association, will be held October 3, 4 and 5, 1958, at the Claremont Hotel, Berkeley. Other participants in the conference are the Western Industrial Nurses Association, the American Industrial Hygiene Association, the American Society of Safety Engineers, and the American Conference of Governmental Industrial Hygienists.

The Western Industrial Medical Association will hold its own 17th annual meeting at the Claremont, October 4. Further information may be obtained from Dr. John E. Kirkpatrick, 516 Sutter Street, San Francisco 2, or Dr. A. C. Remington, 9851 Sepulveda Boulevard, Los Angeles 45.

LOS ANGELES

Correction: Dr. Adolph A. Kutzmann of Los Angeles was installed as president of the American Urological Association at the annual meeting in New Orleans.

A news item printed in this section in the June issue gave his name as Ralph.

* * *

Following is a list of the new officers of the **Pediatric Section of the Los Angeles County Medical Association:** President, Dr. Wendell Redfern; vice-president, Dr. Morris Naiditch, and secretary-treasurer, Dr. Neil N. Litman.

SAN FRANCISCO

The California Medical Association lost a valued employee on June 10 when **Herbert A. Dady,** advertising manager of CALIFORNIA MEDICINE, died in New York. Mr. Dady was on a business trip and was found dead in his hotel room the day before his intended departure for San Francisco.

Mr. Dady served in the advertising department of the Pacific Coast Edition of the *Wall Street Journal* for a number of years before World War II, at which time he entered the army and became a medical corpsman in the Pacific Theater. On his return in 1946 he joined the California Medical Association staff as advertising manager, a position he had filled with distinction until the time of his death.

Surviving Mr. Dady are his wife, mother, one sister and one brother.

* * *

The National Institute of Neurological Diseases and Blindness has included **Children's Hospital,** San Francisco, in a nationwide research project which has been designated the **Collaborative Study of Cerebral Palsy and Brain Damage.** There are 14 other collaborating institutions. Apart from the University of Oregon, Children's Hospital is the only institution west of the Rockies participating in this study. It is one of the only two institutions which will be using private practitioners and private patients.

The objective of this study is a large scale ecological, statistically oriented survey to determine causative factors of central nervous system abnormalities in infants and children. Information about a large and random sample of pregnant women will be obtained and the children produced by these pregnancies will then be studied for the first six years of life. The infants and children will be given neurological, psychological and developmental examinations at designated ages up to six years.

* * *

Dr. Ernest S. Rogers was elected president of the San Francisco Heart Association at its annual meeting in June. Dr. Rogers succeeds Dr. Vernon C. Harp, Jr.

Two young scientists were honored by the association as **winners of the Kerr and Jones Awards.** Dr. Philip L. Dern, senior resident in medicine at Moffitt Hospital, University of California Medical Center, won the William J. and Dorothy Fish Kerr Prize for the best original clinical observation of heart patients. This award was established in 1957 to encourage young physicians in "the use of the special senses and the sense of touch at the bedside." Dr. Dern's observations concerned the "Pickwickian syndrome" or chronic drowsiness in obese patients.

The T. Duckett Jones Memorial Prize for an essay on rheumatic fever by a medical school undergraduate was awarded to Jordan R. Wilbur, president of the freshman class at the Stanford University School of Medicine. This prize was made possible by memorial contributions from friends and admirers of Dr. Jones in memory of his outstanding work in the field of rheumatic fever. Mr. Wilbur's essay discussed the problem of "Anxiety in Children with Rheumatic Fever."

* * *

The fifth annual series of **surgical symposia,** sponsored by the San Francisco Academy of General Practice, and to be given by the surgical service of the **Fort Miley Hospital** of the Veterans Administration in cooperation with the faculties of Stanford and University of California schools of medicine, will start on Tuesday evening, October 14, at 8 p.m. and continue each Tuesday evening for six weeks. The symposia will be moderated by Dr. Louis G. Brizzolara, formerly chief of the surgical service at Fort Miley.

The program and information may be obtained from Alex F. Fraser, chairman, Fort Miley Medical and Surgical Symposia, 3490 20th Street, San Francisco.

TULARE

Dr. Charles W. Folsom was appointed health officer of Tulare County, effective June 1. He replaced Dr. Elmo Zumwalt, the medical director of Tulare County Hospital, who had been serving temporarily as health officer since the death of Dr. Elmo Alexander earlier this year.

GENERAL

The American Urological Association has announced the opening of competition for its annual award of $1,000 (first prize $500, second prize $300, and third prize $200) for essays on the result of some clinical or laboratory research in urology. Competition is limited to urologists who have been graduated not more than ten years and to hospital interns and residents doing research work in urology.

The first prize essay will appear on the program of the forthcoming meeting of the American Urological Association, to be held at the Chalfonte-Haddon Hall, Atlantic City, New Jersey, April 20 to 23, 1959.

Full particulars may be obtained from the Urological Association's executive secretary, Mr. William P. Didusch, 1120 North Charles Street, Baltimore, Maryland. Essays must be in his hands before December 1, 1958.

* * *

Plans have been made for the second annual convention of the **American Association of Medical Assistants** to be held at the Palmer House, Chicago, Illinois, on October 31 and November 1 and 2, 1958. Now a little more than two years since its formation, the association has a membership of nearly 6,000 distributed over 17 states.

The purposes of the association are to improve the services rendered by the assistants to the medical profession and to the public, to cooperate with the medical profession in improving public relations and to render educational services for the self-improvement of its members.

Inquiries about the association may be addressed to Miss Hallie Cummins, R.R.L., chairman of the Public Relations Committee, Medical Record Library, Caro State Hospital for Epileptics, Caro, Michigan.

* * *

An interim meeting of the **American Institute of Ultrasonics in Medicine** will be held at the Bellevue-Stratford Hotel, Philadelphia, August 23, 1958. Further information may be obtained from Dr. John H. Aldes, 4833 Fountain Avenue, Los Angeles 29.

POSTGRADUATE EDUCATION NOTICES

THIS BULLETIN of the dates of postgraduate education programs and the meetings of various medical organizations in California is supplied by the Committee on Postgraduate Activities of the California Medical Association. In order that they may be listed here, please send communications relating to your future medical or surgical programs to: Mrs. Margaret H. Griffith, Director, Postgraduate Activities, California Medical Association, 2975 Wilshire Boulevard, Los Angeles 5.

UNIVERSITY OF CALIFORNIA AT LOS ANGELES

Techniques of Surgery. Monday through Friday (limited to 14), July 28 to August 1. Forty hours: Fee: $500.00.

Internal Medicine (at University of California Residential Conference Center, Lake Arrowhead), Wednesday through Saturday, August 20 to 23. Sixteen hours. Fee $150.00 (including room and meals).

Anesthesiology. Wednesday through Friday, August 27 through August 29. Sixteen hours. Fee: $50.00.

Minor Surgery—Lecture and Laboratory (Laboratory limited). Friday and Saturday, September 5 and 6. Twelve hours.*

Workshop for Food Service Workers I. Monday and Tuesday, September 15 and 16. Twelve hours. Fee: $15.00 includes luncheons.

Medical Terminology. Thursday nights, beginning September 18. Forty-five hours. Fee: $30.00.

Teaching Clinics. Thursday, September 18 to December 11. Twenty-four hours.*

St. Joseph Hospital, Burbank, Postgraduate Medical Lecture Series. Tuesdays, September 23 to December 9. Twenty-four hours.*

Calculations in Clinical Chemistry. Begins in September. Sixteen hours.*

Practical Clinical Chemistry for Laboratory Technologists. Begins in October. Twenty-four hours.*

Aviation Medicine. Wednesday, Thursday and Friday, October 22, 23 and 24. Nineteen hours.*

Removal of Foreign Bodies from Lung and Bronchi. Saturday and Sunday, November 8 and 9. Nine hours. Fee: $110.00.

Contact: Thomas H. Sternberg, M.D., Assistant Dean for Postgraduate Medical Education, U.C.L.A., Los Angeles 24. BRadshaw 2-8911, Ext. 7114.

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

Microbiology and Immunology in Clinical Medicine. Tuesday through Friday, July 22 through July 25. Sixteen hours. Fee: $40.00.

Refresher Course in Anatomy. Monday through Friday, July 28 through August 1. Thirty-five hours. Fee: $75.00.

Physiology and Pharmacology in Clinical Medicine. Monday through Tuesday, August 4 through August 12. Thirty-two hours. Fee: $75.00.

Fundamental Principles of Radioactivity and the Diagnostic and Therapeutic Uses of Radioisotopes. Two or three month course limited to one enrollee per month. Fee: $350.00.

Contact: Seymour M. Farber, M.D., Head, Postgraduate Instruction, Office of Medical Extension, University of California Medical Center, San Francisco 22. MOntrose 4-3600, Ext. 665.

STANFORD UNIVERSITY SCHOOL OF MEDICINE

Morning Clinical Conferences, each Monday, Room 515. *Contact:* D. H. Pischel, M.D., Professor, Division of Ophthalmology, Stanford University School of Medicine, 2398 Sacramento St., San Francisco 15.

Division of Ophthalmology will present a course in Strabismus, consisting of lectures, demonstrations and seminars. Enrollment limited. August 27 through August 30.

*Fee to be announced.

UNIVERSITY OF SOUTHERN CALIFORNIA, LOS ANGELES

Cardiac Resuscitation. Sponsored by the Los Angeles County Heart Association each Wednesday throughout the year, 4 to 6 p.m., USC Medical Research Building, Room 211, 2025 Zonal Avenue. Residents and interns of Los Angeles County, and all armed forces medical personnel admitted without fee. Tuition for all other physicians $30.00. (Each session all-inclusive.)

Basic Home Course in Electrocardiography. One year Postgraduate Series, electrocardiogram interpretation by mail. Physicians may register at any time and receive all 52 issues. Fifty-two weeks. Fee: $100.00.

Advance Home Course in Electrocardiography. One year postgraduate series, electrocardiogram interpretation by mail. Fifty-two issues: $85.00. Physicians may register at any time.

Special Announcement: From August 5 to August 21, 1958, the University of Southern California School of Medicine will hold a postgraduate course in Honolulu and on board the *S.S. Matsonia.* The course will center around actual case histories, which will be used to emphasize diagnostic and therapeutic features.

Contact: Phil R. Manning, M.D., Director, Postgraduate Division, University of Southern California School of Medicine, 2025 Zonal Avenue, Los Angeles 33. CApital 5-1511.

COLLEGE OF MEDICAL EVANGELISTS

Audio-Visual Postgraduate Refresher Courses. Courses are made up of four or more half-hour lectures each, recorded on hi-fi magnetic tape and illustrated by 35-mm. filmstrips or slides in full color, and adapted for use on any standard tape recorder and filmstrip or slide projector, automatic or manual.

Contact: Paul D. Foster, M.D., chairman, Committee on Audio-Visual Courses, College of Medical Evangelists School of Medicine, 316 North Bailey St., Los Angeles 33.

CALIFORNIA MEDICAL ASSOCIATION POSTGRADUATE COURSES

POSTGRADUATE CIRCUIT COURSES

SACRAMENTO VALLEY CIRCUIT for Dunsmuir, Chico, Marysville and Auburn, in cooperation with Stanford University School of Medicine begins week of October 13, 1958.

NORTH COAST CIRCUIT for Eureka, Ukiah and Napa, in cooperation with University of California, San Francisco, begins week of October 13, 1958.

WEST COAST CIRCUIT for San Luis Obispo, Santa Maria and Ojai, in cooperation with College of Medical Evangelists, November 11, 12 and 13, 1958.

POSTGRADUATE INSTITUTES—1959

SAN JOAQUIN VALLEY COUNTIES in cooperation with College of Medical Evangelists, March 19 and 20, Hotel Californian, Fresno. (Local chairman not yet appointed.)

SOUTHERN COUNTIES in cooperation with University of California, San Francisco, April 23 and 24, Disneyland. Chairman: E. F. Cain, M.D., 200 N. Palm, Anaheim.

WEST COAST COUNTIES in cooperation with Stanford University School of Medicine, May 14 and 15, La Playa Hotel, Carmel. Chairman: Chester G. Moore, Jr., M.D., 440 E. Romie Lane, Salinas.

NORTH COAST COUNTIES in cooperation with UCLA School of Medicine, June 5 and 6, Hoberg's Ranch, Lake County. Chairman: Lee Zieber, M.D., 1177 Montgomery Dr., Santa Rosa.

SACRAMENTO VALLEY COUNTIES in cooperation with University of Southern California School of Medicine, June 25, 26 and 27, Tahoe Tavern, Lake Tahoe. Chairman: Robert H. Quillinan, M.D., 616 Alhambra Blvd., Sacramento.

Contact: One of the chairmen listed above, or Postgraduate Activities Office, California Medical Association, 2975 Wilshire Boulevard, Los Angeles 5.

* * *

AUDIO DIGEST FOUNDATION, a nonprofit subsidiary of the C.M.A., now offers (on a subscription basis) a series of hour-long tape recordings designed to keep the physician abreast of current happenings in his particular field. Composed of practice-useful abstracts from 600 leading journals, with short lectures and editorial comments from prominent physicians, Audio Digest offers programs covering general practice, surgery, internal medicine, obstetrics and gynecology, and pediatrics.

AUDIO-DIGEST plans to begin a new series of programs covering the specialty of Anesthesiology. The first of these will be issued on November 1, 1958. Those wishing to be charter subscribers to this tape-recorded review of what is new and important in the field of Anesthesiology should write to Mr. Claron L. Oakley, Editor, 1919 Wilshire Boulevard, Los Angeles 57, HUbbard 3-3451, for order form and further information.

Contact: Claron L. Oakley, editor, 1919 Wilshire Blvd., Los Angeles 57.

Medical Dates Bulletin

JULY AND AUGUST MEETINGS

NEW MEXICO CHAPTER ACADEMY OF GENERAL PRACTICE Ruidosa Summer Clinic, July 21 through July 24, Ruidosa, New Mexico. *Contact:* Frederick R. Brown, M.D., secretary-treasurer, 207 N. Union, Roswell, New Mexico.

WESTERN REGIONAL MEETING, INTERNATIONAL COLLEGE OF SURGEONS, Riverside Hotel, Reno, Nevada, August 21 to 23. *Contact:* Leo D. Nannini, M.D., 190 Mill Street, Reno, Nevada. For reservations, write Riverside Hotel, Reno, Nevada.

FALL AND WINTER MEETINGS

OREGON STATE MEDICAL SOCIETY 84th Annual Session, September 3 to 5, Masonic Temple, Portland. *Contact:* Roscoe K. Miller, executive secretary, 1115 S. W. Taylor St., Portland 5, Oregon.

SAINT JOHN'S HOSPITAL POSTGRADUATE ASSEMBLY, September 11 through September 14, Saint John's Hospital, Santa Monica. *Contact:* John C. Eagan, M.D., director, Postgraduate Assembly, 22nd St. at Santa Monica Blvd., Santa Monica.

STOCKTON POSTGRADUATE STUDY CLUB 20th Annual Fall Series, September 11 to November 13, 8 p.m., College of Pacific Campus, Stockton. *Contact:* John F. Blinn, Jr., M.D., chairman, 936 N. Commerce St., Stockton.

WASHINGTON STATE MEDICAL ASSOCIATION Annual Convention, September 14 to 17, 1958, Spokane, Washington. *Contact:* Ralph W. Neill, executive secretary, 1309 Seventh Ave., Seattle, Wash.

TWELFTH ANNUAL POSTGRADUATE ASSEMBLY, September 17 and 18, San Diego County General Hospital, San Diego. *Contact:* William T. Nute, executive secretary, San Diego County Medical Society, 3427 Fourth Avenue, San Diego 3.

NEVADA STATE MEDICAL ASSOCIATION Annual Meeting, September 17 through 20, Elko, Nevada. *Contact:* Nelson B. Neff, executive secretary, P. O. Box 188, Reno.

PACIFIC DERMATOLOGIC ASSOCIATION Tenth Annual Meeting, September 18 through 20, Hotel del Coronado, Coronado, Calif. *Contact:* Louis H. Winer, M.D., secretary-treasurer, 9915 Santa Monica Blvd., Beverly Hills, Calif.

COLORADO STATE MEDICAL SOCIETY Annual Session, September 24 through 27, Broadmoor Hotel, Colorado Springs. *Contact:* Harvey T. Sethman, executive secretary, 835 Republic Bldg., Denver 2.

CALIFORNIA DIVISION OF THE AMERICAN CANCER SOCIETY Annual Meeting, October 1 to 4, Fairmont Hotel, San Francisco. On Wednesday, October 1, afternoon and evening, will be a cancer conference held for entire medical profession. *Contact:* Walter E. Batchelder, M.D., medical director, C.M.A. Cancer Commission, 450 Sutter St., San Francisco 8.

1958 WESTERN INDUSTRIAL HEALTH CONFERENCE sponsored by the Western Industrial Medical Association, October 3 to 5, Claremont Hotel, Berkeley. *Contact:* John E. Kirkpatrick, M.D., 516 Sutter St., San Francisco 2; or A. C. Remington, M.D., 9851 Sepulveda Blvd., Los Angeles 45.

CALIFORNIA ACADEMY OF GENERAL PRACTICE Tenth Annual Scientific Assembly, October 5 to 8, Masonic Temple, San Francisco. *Contact:* William W. Rogers, executive secretary, 461 Market Street, San Francisco 5.

FIFTH ANNUAL FORT MILEY SURGICAL CLINICS AND SYMPOSIA sponsored by the San Francisco Academy of General Practice in cooperation with Faculties of Stanford University School of Medicine and University of California School of Medicine at Fort Miley Veterans Administration Hospital, 42nd Avenue and Clement Street, San Francisco, will start on October 14, 1958 at 8 p.m. and each Tuesday thereafter ending November 18, 1958. *Contact:* Alexander F. Fraser, M.D., 3490 20th Street, San Francisco.

CALIFORNIA SOCIETY OF INTERNAL MEDICINE Annual Meeting, October 17 to 19, Ahwahnee Hotel, Yosemite. *Contact:* Mrs. Mildred B. Coleman, executive secretary, or Dr. Clyde C. Greene, secretary-treasurer, 350 Post St., San Francisco 8.

AMERICAN HEART ASSOCIATION Scientific Sessions and Meetings, October 24 to 28, Fairmont Hotel and Civic Auditorium, San Francisco. *Contact:* J. Keith Thwaites, executive director, California Heart Association, 1428 Bush Street, San Francisco 9.

LOS ANGELES COUNTY HEART ASSOCIATION 28th Annual Professional Symposium, October 29 and 30, Wilshire Ebell Theater. *Contact:* Los Angeles County Heart Association, 660 S. Western Ave., Los Angeles 5, DUnkirk 5-4231.

HAWAII HEART ASSOCIATION, INC. Special Cardiological Sessions, October 30 through November 1, Princess Kaiulani Hotel, Honolulu. *Contact:* Alfred S. Hartwell, M.D., c/o Hawaii Heart Association, 1018 Lunalilo St., Honolulu.

SAN DIEGO COUNTY HEART ASSOCIATION 8th Annual Symposium on Heart Diseases, all day, October 31, U. S. Naval Hospital Auditorium, San Diego. *Contact:* O. M. Avison, executive director, San Diego County Heart Association, 1651 Fourth Ave., San Diego, BElmont 4-5101.

SANTA BARBARA COUNTY HEART ASSOCIATION, Professional Symposium, 9 to 5 p.m., November 1, Biltmore Hotel, Santa Barbara. *Contact:* Mrs. Katherine McCloskey, executive director, 18 La Arcada Court, Santa Barbara.

CALIFORNIA SCHOOL HEALTH ASSOCIATION annual meeting, November 8 and 9, Hacienda Hotel, Fresno. *Contact:* Miss Kathleen Fox, health educator, City of Long Beach Department of Public Health, 2655 Pine Ave., Long Beach 6.

CALIFORNIA MEDICAL ASSOCIATION Annual Meeting, February 22 through February 25, 1959, Palace Hotel, San Francisco. *Contact:* John Hunton, executive secretary. 450 Sutter Street, San Francisco 8; or Ed Clancy, director of Public Relations, 2975 Wilshire Blvd., Los Angeles 5.

THE PHYSICIAN'S *Bookshelf*

GENERAL TECHNIQUES OF HYPNOTISM—Andre M. Weitzenhoffer, Ph.D., Stanford University and Center for Advanced Study in the Behavioral Sciences (1956-1957). Grune and Stratton, Inc., New York, 1957. 460 pages, $11.50.

This is a volume devoted to a rather exhaustive review of hypnotic techniques. It presents the principles and implementation of these techniques in considerable detail, and the author's descriptions of methods are written in a lucid and graphic style.

The limitations of this volume, however, are considerable. For example, the author states in the preface that in the effective use of hypnosis recognition must be given to the psychological make-up of the subject or patient, and that "Such an approach calls for a thorough understanding of the dynamics of the situation." In the same chapter, however, he indicates that the portion of the book dealing with these dynamics may be found too difficult by some readers, and may be overlooked. In effect, this inconsistency suggests a sort of clinical irresponsibility in which the author implicitly subscribes to the practice of hypnotism without that very dynamic understanding which he previously defines as essential. This in many ways is tantamount to publishing a book on surgical techniques, and suggesting to the reader that if he finds anatomy, physiology, bacteriology, and pathology too difficult to understand, he may overlook these subjects, proceed on his surgical career, and perhaps pick up his theoretical knowledge on the way.

The volume contains occasional brief references to the dangers of hypnosis, and, to its credit, proclaims its undesirability as a public entertainment technique. Theoretical considerations contained in the "optional" chapter already alluded to are murkily handled, and psychoanalytic conceptions of hypnosis are presented, but arbitrarily rejected. It can be understood that the psychoanalytic attitude toward hypnosis is not convincing to the author because psychoanalysts view hypnosis as an extremely powerful interpersonal transaction which requires careful training of the hypnotist in theoretical and clinical psychodynamics. An author convinced of this principle would not be satisfied with the writing of a "do-it-yourself" book on the techniques of hypnotism.

H. R. Brickman, M.D.

* * *

CORTISONE THERAPY—J. H. Glyn, M.A. (Cantab), M.D., M.R.C.P., D. Phys. Med., Consultant in Physical Medicine to the Prince of Wales and Tottenham Group of Hospitals, London, England. Mainly applied to the Rheumatic Diseases. Philosophical Library, Inc., Publishers, 15 E. 40th Street, New York 16, N. Y. 162 pages, $10.00.

The author has attempted to appraise the role of cortisone and its newer derivatives in the treatment of various disorders, but primarily the rheumatic diseases. The chapters dealing with the chemistry, pharmacology and side effects of these steroids are excellent and are highly recommended. There is an extensive discussion of the practical aspects of therapy in rheumatoid arthritis with particular reference to the selection of patients to be treated, schedules of dosage, precautions to be taken and problems likely to be met. Indications for intra-articular injections are described and are supplemented by an appendix showing anatomical approaches to the various joints.

There is a brief chapter discussing the use of corticosteroids in "collagen vascular" diseases, and in dermatological, gastrointestinal, respiratory, renal, ophthalmological, endocrine, hematologic and other disorders.

The author writes clearly and the material is well organized. Although aware of the need for brevity, he tends to be dogmatic and omit dissenting opinion. Where his personal experience has been extensive, in the management of rheumatoid arthritis, his opinions and conclusions deserve consideration. The difficulty of this approach is evident in the section on nonrheumatic disorders where many observers will not agree with all of the opinions expressed by the author. It seems to the reviewer that this section could have been omitted.

Although corticosteroid therapy appears limited to 10 per cent of patients with rheumatoid arthritis, this book is recommended for all rheumatologists and deserves a place on all medical library shelves.

Amos H. Lieberman, M.D.

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MEDICAL JURISPRUDENCE AND TOXICOLOGY—Tenth Edition—John Glaister, J.P., D.Sc., M.D., F.R.S.E., F.R.F.P.S. (Glasg.), of the Inner Temple, Barrister-at-Law, Regius Professor of Forensic Medicine, University of Glasgow; President of the Association in Forensic Medicine in collaboration with Edgar Rentoul, M.B.E., M.A., LL.B., Ch.B., Lecturer in Forensic Medicine, University of Glasgow. The Williams & Wilkins Co., Baltimore, Md. 720 pages, $10.00.

The 1957 (Tenth) edition of "Medical Jurisprudence and Toxicology" (first printing 1902) is essentially a reprint of the recent editions with only minor changes. Those additions specified in the preface deal primarily with new statutes and acts in the English law. These might well serve those who have occasion to take interest in new forensic legislation being contemplated for American law. It would appear that there is much we could learn from the British in this regard.

The book treats the subject of legal medicine quite capably and offers an excellent reference source or method of review of the important elements of the field. More detailed volumes treating specified fields in greater detail should be used by those working in the field, while the beginner or one seeking a quick refresher on some general point would find the volume herein reviewed of some appreciable usefulness.

While well and fully illustrated, the color plates leave much to be desired.

In general, the book would be valuable in any library for reference or elementary training.

PHARMACOLOGY AND THERAPEUTICS—A Textbook for Students and Practitioners of Medicine and Its Allied Professions—Third Edition—Arthur Grollman, Ph.D., M.D., F.A.C.P., Lecturer in Pharmacology and Toxicology, The Medical Branch, and Professor and Chairman of the Department of Experimental Medicine, The Southwestern Medical School, The University of Texas, Attending Physician, Parkland Memorial Hospital; Consultant in Internal Medicine, Baylor University Hospital; Consultant, Veterans Administration Hospital, Dallas, Texas; Civilian Consultant, The Surgeon General U. S. Air Force. Lea and Febiger, Washington Square, Philadelphia, Pa., 1958. 1,034 pages, $12.50.

This third edition by a real teacher, lucid writer, able investigator and sound clinician, is but little changed from the second edition, except for addition of new drugs, better classification by dividing the 44 chapters into 9 groups or parts, and amplifying theoretical sections. There is a new chapter for incorporating the Psychotomimetic and Tranquilizing Drugs, serotonin, lysergic acid diethylamide, the Rauwolfia alkaloids, chlorpromazine, meprobamate and their newer competitors. The book clearly explains drug effects on the basis of the pharmacological actions, as would be expected, but it goes beyond animal pharmacology and explains therapeutic uses from the point of view of both the pharmacologist and the clinician. There is a sufficient number of structural chemical formulas to show relations of the different drugs within a class, and to illustrate dependence of action upon the chemical nature of the drug; there are numerous chymograph tracings, graphs, charts, tables, drawings and photographs to illustrate the text.

Dr. Grollman retains the conventional arrangement of the book, with general statements, definitions, theories and principles in Chapter 1, Part I. The reviewer has maintained for years that such material should either be scattered through a textbook, where specific value or interest would occasion the discussion of the principle or theory, or should be included in a chapter toward the end of the book, so that the reader would have knowledge of specific details from which to induce generalities. This follows the pedagogical rule of going from the concrete to the abstract. Few authors follow this rule.

Another feature of his book is the absence of specific solubility data in the discussion of preparations and doses. Perhaps in this era of finished pharmaceutical preparations, requiring but rare prescribing of extemporaneous solutions, the physician, and hence, the student, has little need for such specific information, but teachers of the older school, of whom few are left in the active teaching field, miss seeing this information in a textbook of pharmacology.

Part II includes 8 chapters on drugs acting primarily on the central nervous system. From the pedagogical point of view it is unfortunate that depressants of the central nervous system are discussed first, for their mechanisms of action are poorly understood and except for recent work on the reticular formation and the arousal mechanism even the site of action within the central nervous system is not known. Thus the student's first contact with drugs is not conducive to clear thinking about site and manner of action. It would have been better to begin with central nervous system stimulants, such as strychnine, pentylenetetrazol and picrotoxin, whose pharmacology is more readily demonstrated, which are not discussed until chapter 8, or better still, with acetylcholine, a peripherally acting drug with easily demonstrable and understood action.

Part III is devoted to peripherally acting drugs, mostly those classified as "autonomic drugs" and as local anesthetics.

Part IV contains five chapters devoted to drugs acting on heart, blood vessels, kidneys, intestine and blood, such as digitalis, nitrites, Rauwolfia, antacids, xanthines, antianemic drugs and anticoagulants. Part V contains the anti-infective or chemotherapeutic agents, in eight chapters. Part VI discusses endocrine products; Part VII the vitamins; Part VIII the minerals, and Part IX vaccines, toxins, immune sera and antitoxins and miscellaneous diagnostic and therapeutic preparations.

Prescription writing is relegated to an appendix, and there is a useful therapeutic classification of drugs, also an appendix. Two valuable portions of the introduction are the brief but scholarly historical account of pharmacology on pages 22 to 24 and statistical considerations on pages 32 to 34.

With actual text material confined to 937 pages of relatively small size and easily read type, there is not too much material for a student to cover in a one-semester course in pharmacology, but there is enough basic pharmacology and indications of therapeutic uses and effects to introduce the student to the subject and to meet most of the needs of the practitioner.

CLINTON H. THIENES, M.D.

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SPINAL ANESTHESIA—John B. Dillòn, B.S., M.S., M.D., Professor of Surgery and Chief of the Division of Anesthesia, Dept. of Surgery, University of California Medical Center, Los Angeles; Consulting Anesthesiologist to the Wadsworth General Hospital, Veterans Adm. Center, Los Angeles, Huntington Memorial Hospital, Pasadena, St. Johns Hospital, Santa Monica, Cedars of Lebanon Hospital, Los Angeles, Los Angeles County Hospital, Los Angeles; formerly Associate Clinical Professor of Surgery (Anesthesia), University of California (Southern) and the College of Medical Evangelists, Los Angeles; Chief of Dept. of Anesthesia, Los Angeles County Hospital. Charles C. Thomas, Publisher, 301-327 E. Lawrence Ave., Springfield, Ill. 61 pages, $3.00.

This little 61-page monograph in the American Lecture Series should fulfill one of the author's hopes "that it will be a stimulus to residents in anesthesiology by causing them to look further into many phases of spinal anesthesia about which there is much to learn." On the other hand it may fall short of assisting the anesthetist who has neither the time nor the opportunity to explore some of its facets.

This book, which makes no pretense at being an exhaustive treatise, is in fact an account of the author's viewpoint on spinal anesthesia. For the medical student or new resident in anesthetics it possesses such qualities as brevity and tone of final authority so dear to their hearts.

Chapters on "Indications for Spinal Anesthesia," "Contraindications to Spinal Anesthesia," "Advantages and Disadvantages," "Equipment," "Drugs and Sterilization," afford the reader a clear and concise reflection of the author's assessment.

Many experienced anesthetists will be annoyed to be cautioned "Under no circumstances should a dose of 5 mg. of tetrocaine be exceeded for caesarean section." On the other hand they might question the advisability of adding epenephrine to increase the duration of anesthetic action in 50 per cent of cases.

The reviewer is inclined to believe the author's somewhat inflexibility in some matters along with his tendency to use "Pathology" as a synonym for lesion can be excused inasmuch as it has not interfered with the production of a brief informative text.

Dr. Dillon has drawn upon his wide experience to give something of value to all physicians who are interested in spinal anesthesia.

WILLIAM B. NEFF, M.D.

THEORY AND PROBLEMS OF CHILD DEVELOPMENT—David P. Ausubel, M.D., Ph.D., Bureau of Educational Research, University of Illinois, Grune & Stratton, New York, 1958. 650 pages, $12.00.

This book exhibits a tremendous effort in research. In the 650 pages, the author includes 77 pages of references. The author index accounts for nine pages. The subject matter is well indexed in 29 more pages.

Reading is heavy and laborious for the chapters abound in 50-or-more word sentences and the author delights in filling these sentences with six-syllable words.

The author states that the book is intended as an advanced text for graduate students in psychology and education but might be used for mature undergraduates adequately prepared in psychology. He also intends it as a reference work for pediatricians, clinical psychologists and psychiatrists. Unless the pediatrician were well grounded in the language of the psychologist he would find himself lost in most of the chapters. He would long for brevity and simplicity of expression.

The book is divided into four parts. Part I deals with the general theoretical and methodological issues in child development. Part II considers the origins, raw materials and beginning status of behavior and capacity. Part III deals with the general theory of personality development. Part IV is concerned with special aspects of development which are relatively more peripheral and less ego-related. It would be in Part IV that the pediatrician would find himself more at home.

As the title states the text is largely theoretical. Very few examples are cited to elucidate these theories. The author rejects or criticizes many of the theories as expounded by Freud, Watson, Gesell and others. The lowly reader wonders if the theories expounded are really what makes the child tick.

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REPORT OF THE SCIENTIFIC DIRECTOR—1957—Clarence Cook Little, Sc.D., Chairman, Scientific Advisory Board. Tobacco Industry Research Committee. 150 East 42nd Street, New York 17, N. Y. 49 pages.

This small monograph consists of abstracts of twenty scientific papers dealing with various phases of research directly or indirectly connected with the potential effect of certain noxious agents on normal and abnormal pulmonary, cardiovascular, cutaneous and other tissues.

Dr. C. C. Little, the scientific director of the Tobacco Industry Research Committee, makes the following points as a result of the investigations referred to:

1. Prolonged exposure of the lungs of rodents to massive doses of cigarette smoke has failed to produce bronchogenic cancer.

2. Tobacco smoke condensates have failed to produce cancer, even on the skin of susceptible mice, when applied at a rate and quantity simulating conditions of human smoking.

3. Peripherovascular constriction following nicotine ingestion does not occur routinely; it is found only in certain persons under certain conditions.

4. In one study of the effect of cigarette smoking on gastric secretions of patients with duodenal ulcer, such smoking did not produce significant changes in such secretions.

The Scientific Advisory Board of the Tobacco Research Committee includes distinguished investigators such as Julius H. Comroe, Jr., Leon O. Jacobson, Paul Kotin, Stanley Reimann, and Edwin B. Wilson. It was organized almost five years ago and functions as an independent body in the allocation of grants for research, the amounts appropriated to date being approximately $2,200,000. Primary attention has been given to research projects relating to cancer and heart ailments, but funds have also been allocated to basic and unrelated projects. Investigations are also under way in connection with the sociological and psychological aspects of the kind of people who become excessive smokers.

Progress of medical research is slow and painstaking. The factor of multiple causation in human diseases prevents simple elucidation of many problems. While excessive intake of carbohydrates, fats, ethyl hydrates and tobacco smoke is unquestionably harmful, the precise position of moderate usage of some of these materials is still unsettled.

The report includes a list of grantees and project titles, the former numbering many well known research workers and university professors in this state. The monograph should be of interest to physicians questioned regarding the apparent noxious properties of Lady Nicotine.

L. H. GARLAND, M.B.

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THE STUDENT LIFE (The Philosophy of Sir William Osler)—Richard E. Verney, M.B., F.R.C.P.E., D.R., Physician in Charge, Department of Student Health, University of Edinburgh, and Nurses Health Service, The Royal Infirmary of Edinburgh. E. & S. Livingstone, Ltd., Edinburgh and London. The Williams & Wilkins Co., Mt. Royal and Guilford Aves., Baltimore 2, Md. 214 pages, $4.00.

Osler's brilliant popular writings, addressed often to medical students or nurses, have been famous for fifty years. Now Dr. Verney gives us for the first time an anthology of this material in the form of excerpts from the various essays grouped together according to subject such as "The Student of Medicine," "The Professor of Medicine," "A Way of Life," et cetera. Osler's philosophy was one of hard, unremitting work, but not necessarily divorced from broad humanitarian subjects. Himself a great bibliophile, he wrote brilliantly with rich allusions to lay and professional literature. He preached and practiced imperturbability, equanimity and courage in adversity; it was his life's tragedy that all these failed him with the death of his son in the first world war.

Every medical student and doctor should own and frequently re-read these works of the master physician of the late 19th century.

ARTHUR L. BLOOMFIELD, M.D.

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THE MEDICAL WORLD OF THE EIGHTEENTH CENTURY—Lester S. King, M.D., University of Chicago Press, Chicago 37, Illinois, 1958. 346 pages, $5.75.

In this loosely correlated series of essays Dr. King conveys the spirit of 18th century medicine. There is much interesting material here such as the excellent account of Hahnemann (Similia Similibus), the growth of medical ethics, fevers, and many others. Perhaps the author does not make clear as precisely as possible the rather sharp dividing line between the 18th and 19th centuries. The eighteenth was definitely oriented backwards—to Galen. All one need do to convince himself of this is to read discussions about the nature of disease and its treatment written before 1800. With the development of that brilliant school of pathologist-clinicians in Paris, typified by such men as Laennec and Louis, however, the whole outlook changed. The mysticism and empiricism of the past were thrown off like a confining shell and a new attitude of exact inquiry and observation took its place; with this group began modern medicine with remarkable distinctness.

Dr. King's book is instructive and entertaining but should be read more as part of the history of civilization rather than of medicine.

ARTHUR L. BLOOMFIELD, M.D.

INTEGRATING THE APPROACHES TO MENTAL DISEASE—Two Conferences Held under the Auspices of the Committee on Public Health of the New York Academy of Medicine—Edited by H. D. Kruse, M.D., Executive Secretary, Committee on Public Health, New York Academy of Medicine. Paul B. Hoeber, Inc., 49 East 33rd Street, New York 16, N. Y., 1957. 393 pages, $10.00.

This volume contains the proceedings of two conferences on the subject of the several approaches to the problem of mental disease. Forty-eight experts from several disciplines participated in this work. The general plan was approximately the same for the two conferences.

The conferences were opened with statements on the etiology of mental illness from the organic, the experimental psychological, the psychodynamic and the psychosocial points of view. After this initial presentation of the several points of view the discussion was organized under headings (in the first conference) of areas of interdoctrinal acceptance and areas of interdoctrinal unacceptance. The discussion continued to include items such as evidence of interrelation among doctrines, searching for common ground and a consideration of problems of communication and concepts. Finally, time was devoted to a discussion of steps necessary for further study in connection with the problem of integrating the several approaches.

In reading the introductory papers and the following discussion one gets the impression that the participants were genuinely interested in the attempt to understand each other, but there are many instances in which difficulties were encountered. In some cases this appeared to be the result of wide differences in fundamental points of view. In other cases it appeared to be largely a matter of technical language differences.

There is no question but that this is a laudable attempt, and there is a great deal of evidence to suggest that this type of interdisciplinary effort will be made more frequently in the future. While it is well to keep in mind that these conferences are concerned with several aspects of the mind-body problem, which remains unsolved, and the relationship of the human to the environment, there is reason to believe that studies of this kind will ultimately be of great aid in a better understanding of problems of mental illness.

While this work may be of some interest to the general medical reader it seems more likely that it will be of most value to those who are working directly in the field of mental illness, either in research or clinical positions.

CHARLES W. TIDD, M.D.

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PRACTICAL PEDIATRICS—R. Cannon Eley, M.D., Assistant Clinical Professor of Pediatrics, Harvard Medical School, and Benjamin Kramer, M.D., Director of Pediatrics Services, Maimonides Hospital, Brooklyn, Clinical Professor of Pediatrics (Emeritus), State University of New York, Medical Center, New York City. Landsberger Medical Books, Inc., distributed by the Blakiston Division of the McGraw-Hill Book Co., New York City. 309 pages, $7.00.

This is well written and is easy to read. It covers most of the more common conditions and illnesses which may affect infants and children. There is enough information presented for each subject discussed to make a diagnosis possible and the outlines of treatment are in keeping with modern and up-to-date concepts.

If the general practitioner would search, read and follow the information presented there would be few failures of diagnosis and he would possess a fair knowledge of physical and pathological conditions that affect children, and have a method of treatment at hand.

Two chapters are given over to the care of the newborn and prematures. In the chapters on feeding more emphasis is given to breast feeding, its value and technique, than to formula feeding. Diets for various age groups are outlined.

The common contagious diseases are discussed with diagnosis, treatment and active immunization procedures. The chapter on diabetes mellitus is so deficient that the general practitioner without much more detailed knowledge than here presented, would not fare well in handling a diabetic child. The chapter on fluid and electrolyte balance gives much necessary information. The authors finish the book with a chapter on poisons and antidotes.

Perhaps the publisher could be criticized for placing eight pages of wholly unrelated x-ray photographs in the midst of the chapter on "Immunization Procedures."

E. EARL MOODY, M.D.

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AN ATLAS OF THE COMMONER SKIN DISEASES—Fifth Edition—Henry C. G. Semon, M.A., D.M. (Oxon.), F.R.C.P. (London)—Revised with the Collaboration of Harold T. H. Wilson, M.A., M.D. (Cantab.), M.R.C.P., D.T.M. The Williams and Wilkins Company, Baltimore, 1957. 375 pages, with 153 plates reproduced by direct color photography from the living subject, $20.00.

The format of the book is such that on one page a color photograph is presented and on the adjacent facing page is a description pointing out the salient features in the photograph. The usual common skin disorders are represented. Some of the rare skin disorders are presented. Many of the photographs are excellent, but a surprising number are only average.

A small part of the legend describing each skin disorder is devoted to treatment. The book has value for those who desire a complete reference file of books in the field of dermatology. However, for those who like to browse through many pictures, looking for sharp salient features of the various skin disorders, it may prove disappointing.

HAROLD M. SCHNEIDMAN, M.D.

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THAT DEGENERATE SPIROCHETE—Oscar Daniel Meyer, M.D. Vantage Press, Inc., 1952.

Oscar Daniel Meyer was born in 1883, and was licensed to practice medicine in 1910. In 1920, he was told by a spiritualist that he would make his living in medicine mainly by administering injections and that a particular patient would appear with a temporal ulcer, which he should diagnose and treat as syphilis. On 24 October, 1925, at one in the morning, he experienced a spiritual manifestation in the form of a disembodied voice which instructed him to "go through with this subject, namely syphilis." A year later, the predicted patient with an ulcer on her temple appeared and he was fully embarked on his career.

This is his book about syphilis and the *Spirochaeta pallida*, to which he infers the cause of everything from acne to xanthoma, not neglecting diabetes, rheumatic fever and hundreds of other disorders. He doesn't say syphilis is the only cause. However, his attitude appears to be that you can never be sure, and a little trial of antisyphilitic therapy will prove the point. His therapy consisted mainly of intravenous mercurochrome at the time the book was published. On his last page, he acknowledges that penicillin is also very good; now, six years later, he must be even more firmly convinced of its value. Since it cures syphilis, and also abates many various disease conditions, he has further evidence that syphilis is the underlying cause of these various syndromes.

His devotion to the prevention of disease is highly praiseworthy, though many would disagree with the fear motivation which he advocates to discourage sexual promiscuity, and more would doubt the dogmas which he offers as facts.

PHYSICAL DYNAMICS OF CHARACTER STRUCTURE—Bodily Form and Movement in Analytic Therapy—Alexander Lowen, M.D., Executive Director, Institute for Bioenergetic Analysis, New York. Grune and Stratton, New York, 1958. 358 pages, $7.75.

The author states that this book attempts to bridge the gap between psychoanalysis and the concept of a physical approach to emotional disorders. Many of the roots of the material presented may be seen to rest on the contributions of Wilhelm Reich who was the author's teacher. In essence, the book propounds a theory and technique of what the author calls bioenergetic analysis. The book is divided into two parts. Part One represents Dr. Lowen's attempt to show that bioenergetic analysis is a logical extension of psychoanalysis. He does this by means of many references to Freud's works, and interpretations and extensions of these quotations so as to integrate his own techniques into analytic theory. Part Two is divided into nine chapters covering seven types of character structure, with case material to illustrate the author's approach to treatment of such conditions. Some of the conclusions which the author derives from the quotations from Freud are somewhat disturbing in that they appear to take rather large speculative leaps without there being any real indication in the book of the evidence on which such leaps are based. Certainly, few will take issue with the statement that unconscious attitudes are reflected in muscular tensions of one sort and another. However, conclusion that underdeveloped musculature of the lower extremities indicates that the patient has poor contact with the world; or that "the legs are undercharged and contact with the ground is not maintained . . . and, because of this lack of contact with the ground which is the counterpart of the psychological lack of contact with reality, one feels that these individuals are 'in the clouds,' 'floating somewhere up there,' 'out of touch.'" Nor is it very clear to me how the "lack of turgor in the skin (of a young woman patient) pointed to a very undercharged organism." Conclusions of this sort appear to represent too much a reification of concepts and an equivalence between speculative dynamics and physical structure, the basis for which is not clear to me from reading the book. In the chapter on the bioenergetic concept of the instincts, Dr. Lowen attempts to localize various feelings to various parts of the body, indicating that anger is experienced in the back of the body, specifically in the area between the shoulder blades. He reaches the conclusion that there is a swing of energy along the back, upward, in anger or rage, moving over the scalp and into the upper teeth, and that a downward movement along the back occurs in the sexual act. He illustrates these movements by diagrams portraying energy flow over the body by curved lines which he sees to have a meaning relative to character structure and dynamics.

The therapeutic application of these principles consists of attempting to influence the unconscious attitudes of the patient by means of attacks on the muscular results of these attitudes, as they are postulated. Specifically, the author has his patients beat on the couch with their fists. He requests them to go through various kinds of movement. He utilizes the gag reflex, although I was not able to gather from the book the precise ways in which he uses it. At several points in the book he refers to his techniques as analysis while indicating that he sees the patient once a week, during which sessions the patient would talk in a more conventional way as well as go through the various muscular movements indicated.

It is not possible to evaluate very definitely the effectiveness or lack of effectiveness of the author's techniques, merely from a perusal of this book. The physician inexperienced in psychiatry may mistake the author's speculations for scientific fact, and generally accepted psychiatric theory.

DONALD SCHWARTZ, M.D.

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THE QUEST FOR IDENTITY—Allen Wheelis, M.D. The decline of the superego and what is happening to American character as a result. W. W. Norton & Co., Inc., New York, 1958, 250 pages, $3.95.

The Quest for Identity is a thought-provoking book which will be of interest to social scientists and physicians who are introspective and philosophically minded. Although dealing with the complicated problem of social change and the relation of psychoanalysis to it, it is well written and readable.

While problems like loss of personal identity, longing for the past when life was simpler, when standards were clearer, and relationships closer, have an autobiographical flavor, they are common enough in our society and others will be relieved to see a psychoanalyst, who is too often suspected of having all the answers, struggling with them.

The author properly emphasizes the price that is paid for the greater awareness and knowledge, the increase in complexity of life and the accelerated rate of change of our culture. He comments on the changed role which psychoanalysis plays in society. While in its beginning, it revealed social hypocrisies and was a challenge to the prevailing mores, now that it has become a part of society it has become a force for the maintenance of current mores and uniformity.

He feels that "the group has gained in authority at the expense of conscience. Formerly the standard whereby conduct was judged was within the individual. It was taken from the older generation, but the point is that it was *taken*. It was incorporated by the individual in his childhood and thereafter endured within him, beholden to no one, paying no tribute. Now the standard whereby conduct is judged is coming to be located in the group to which the individual adjusts. Specifically this means that the superego has become weaker, more susceptible to influence. The grounds on which it praises and prohibits are open to argument and particularly, to example."

This is normally the case in the process of maturation. Flexibility replaces the rigidity of the childhood conscience when rigidity is no longer required. The yearning for the past with its strict rules and regulations, its better control over impulses, and its dependence, is a yearning for something that never provides real security. But as the author points out "the chains that enslave also guard one from the unknown. The uses of reason have cut away most of our immemorial myths and superstitions, and without them we cringe in the sharp winds of uncertainty. We have fallen victim to our own power to destroy our myths." Reason cannot achieve certainty and uncertainty causes anxiety which psychoanalysis cannot resolve.

Torn by this dilemma, he feels that there still is a net advantage to the method of science.

NORMAN Q. BRILL, M.D.

Annual Meeting

Civic Auditorium

SAN FRANCISCO

February 22 to 25, 1959

Papers for Presentation

If you have a paper that you would like to have considered for presentation, it should be submitted *to the appropriate section secretary* (see list on this page) no later than September 1, 1958.

Scientific Exhibits

Space is available for scientific exhibits. If you would like to present an exhibit, please write immediately to the office of the California Medical Association, 450 Sutter Street, San Francisco 8, for application forms. To be given consideration by the Committee on Scientific Work, the forms, completely filled out, must be in the office of the California Medical Association no later than September 1, 1958. (No exhibit shown in 1958, and no individual who had an exhibit at the 1958 session, will be eligible until 1960.)

Medical Motion Pictures

There will be facilities available for motion pictures. If you would like to exhibit a film, send your application to Dr. Paul D. Foster, 1930 Wilshire Boulevard, Los Angeles 57. The deadline is October 15, 1958.

SCIENTIFIC PAPERS
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PUBLIC HEALTH . . . . . **Carolyn B. Albrecht**
920 Grand Avenue, San Rafael

RADIOLOGY . . . . . **William H. Graham**
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UROLOGY . . . . . **Earl F. Nation**
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